

HOUSING AUTHORITY
OF THE
COUNTY OF CONTRA COSTA



PART I – REQUEST FOR A REASONABLE ACCOMMODATION

Head of Household Name: _____ Phone: _____

Social Security Number: _____ Other Phone #: _____

Address: _____

Instructions: This form may be used by clients to request a reasonable accommodation so that they may have an equal opportunity to use, enjoy, and participate in any of the programs conducted by the Housing Authority of the County of Contra Costa (HACCC). Part I should be completed by the client. Part II will be mailed to the qualified care provider listed at the bottom of this page. If you need assistance completing this form, contact a Housing Authority representative. If you wish to request a reasonable accommodation in an alternative manner, please contact your caseworker.

The following household member, _____, has a disability as defined below:

Disability: A physical or mental impairment that substantially limits one or more major life activities; a record of having such an impairment; or being regarded as having such an impairment.

Describe the accommodation you are requesting:

Describe why this accommodation is needed and how it relates to a disability:

List the name of the individual who can verify the disability and the need for the accommodation requested. This should be the individual providing professional services that relate to the disability.

Name: _____ Position: _____

Address: _____

Phone: _____

Authorization to Release Information: I authorize the care provider listed above to disclose relevant information to the Housing Authority of the County of Contra Costa regarding the need for a reasonable accommodation. I understand the information the Housing Authority obtains will be kept confidential and used solely to determine if an accommodation should be provided. I hereby authorize my health care provider (name above) to release the requested information on the reverse of this form.

Signature: _____ Date: _____

