Community Development Commission of Mendocino County
1076 N. State St., Ukiah, CA 95482

707/463-5462
Fax: 707/463-4188
TDD: California Relay 711

REQUEST FOR REASONABLE ACCOMMODATION

A reasonable accommodation is a change, adaptation or modification to a policy, program, service, or workplace which will allow a qualified person with a disability to participate fully in a program.

Instructions to CDC Participants, applicants, and others who use the CDC's services and are qualified disabled persons:

- If you would like to ask the CDC for an accommodation to an existing rule, policy, or practice to help with a disability, please complete all parts of this Request Form. It will help the CDC understand your request and respond to it appropriately. Please note that this form is not required to make a request for reasonable accommodation.

- **When you have completed this request, give it to your Housing Programs Specialist,** any CDC personnel, or mail it to: CDC, 1076 North State Street, Ukiah, CA. 95482. If you would like help completing this form or in making a request, please contact CDC at 463-5462.

- The CDC will make every effort to respond to your request <u>within ten business days from receiving all necessary documentation to fully evaluate your request</u>. (Including a medical verification from your provider).

- PLEASE NOTE: If approved for a reasonable accommodation, you will be required to recertify your need for the accommodation at the time of your annual re-certification.

If the disabled Household Member who needs the accommodation is 18 years of age or older, he or she AND the Head of Household must sign this form.

PLEASE PRINT CLEARLY

Directions: If any member of the family is requesting a Reasonable Accommodation from CDC complete pages 1-3 of this form. If no accommodation is necessary no action is required.

Head of Household: _____

Household Member requesting accommodation(s):_____

Address: _____

Daytime Phone: (_____) _____ Cellular Phone: (_____) _____

Name of Household member needing accommodation: _____

DOB:_____

If applicable, relationship to Head of Household (e.g. son, daughter, parent) _____
Is the disability: [ ] **temporary** or [ ] **permanent**

1. As a result of a disability, I am requesting the following reasonable accommodation(s) from the CDC for the disabled Household Member listed above

Please check one or more boxes below

☐ a) A change in the following rule, policy or procedure. (Note: A change in how to meet the requirements of the program may be requested, however, the program requirements must still be met.)

Please state what you are asking CDC to change or provide because of a disability (ex: Allowing a live in aid to reside in an appropriately sized dwelling unit, allowing an additional bedroom for medical equipment, transfer to a downstairs unit before the first year of occupancy, offering documents in an accessible format, permitting an outside agency or person to assist an applicant in meeting the program obligations, sending mail to a person designated as a contact for the person with disabilities.)

2. Without describing the specific type of disability, **state why the above accommodation is necessary.** How does the disability relate to the accommodation that is being requested (ex: can no longer cook, clean or reside alone, can no longer go up and down stairs)

AUTHORIZATION (IF NECESSARY)

Verification of a Reasonable Accommodation may be documented in one of the following ways. Please check the box below indicating how you would like your Reasonable Accommodation request to be verified.

- ☐ I (HOH/SPOUSE or Other Adult) will take this form to a Knowledgeable Professional for completion of Page 4. I will return the completed form (pages 1-4), or other acceptable verification to CDC within 20 calendar days. I understand that failure to return the requested documentation to CDC may result in the denial of the Reasonable Accommodation request. Any extensions to this time frame will be requested for in writing or orally and communicated to CDC.
- ☐ I authorize CDC to contact the Knowledgeable Professional listed below to verify the referenced need for a Reasonable Accommodation. (complete information below) PLEASE NOTE THAT CDC IS NOT REQUIRING YOU TO PROVIDE DIRECT ACCESS TO THE KNOWLEDGEABLE PROFESSIONAL BUT PROVIDING IT AS AN OPTION.

I/We authorize the CDC to verify that the referenced Household Member has a disability and needs a reasonable accommodation. To verify this information, the CDC may contact the below named physician, psychiatrist, licensed psychologist, licensed nurse practitioner, licensed social worker, rehabilitation professional, or non-medical service agency whose function is to provide services to the disabled.

Name of Provider: _____ Field of Practice: _____

Agency/Clinic/Facility: _____

Address: _____

Telephone: (___) _____ Fax: (____) _____

*****If the Household member needing the accommodation(s) is under 18 years of age, are you the parent or guardian of Household Member needing accommodation? [ ] yes or [ ] no**

_____ _____
Signature of Household Member needing the accommodation (only if 18 years or older) Date

_____ _____
Signature of Head of Household (if different than signature above) Date

STOP: <u>DO NOT WRITE BELOW</u>. THE REMAINING PART OF THIS FORM IS TO BE COMPLETED BY A KNOWLEDGEABLE PROFESSIONAL.

Housing Program Specialist:_____
Head of Household: _____

VERIFICATION FROM A QUALIFIED PROFESSIONAL
Please complete questions 1-4, and sign this form. Refer to pages 1-3 for further clarification. Please be as specific as possible. When you have completed this request, return ALL pages to CDC. You may give the completed form to the Participant, fax the form to CDC personnel at (707)463-4188, or mail directly to CDC at 1076 North State St., Ukiah, CA. 95482.

1) Based upon your knowledge: (1) does the above named individual have a physical or mental impairment which substantially limits one or more of the person's major life activities; (2) does the above named individual have a record of such an impairment; or (3) is the above named individual regarded as having such an impairment. **[ ] YES [ ] NO**

2) Is the reasonable accommodation request directly related to his/her disability? **[ ] Yes [ ] No**

3). Describe how the accommodation that the participant is requesting is necessary to afford him/her the opportunity to access housing, maintain housing, or for full use and enjoyment of the housing or otherwise shows the relationship between the impairment and the requested accommodation. The role or the verifier is to establish that the need for the accommodations is derived from the impairment.

For example: Individual can no longer cook, clean, or live alone and therefore requires 24 hour care, individual can no longer go up or down stairs and therefore must transfer to a ground floor unit, individual is in a wheel chair and requires an accessible unit.

NOTE: Please only provide information that demonstrates there is a relationship between a disability and the need for the accommodation listed above. Do not otherwise provide information as to the nature or severity of the disability, or any medical diagnosis.

4) The individual requires [ ] permanent or [ ] short term accommodation.
If short term, please specify the duration required: _____ months/years.

5) [ ] In my professional assessment, the individual's disability does not justify the accommodation requested.

6) I am a qualified professional who is treating the person for his/her disability. Yes No

The statements and opinions I have given are true and correct to the best of my knowledge.

_____ _____
Signature/Title Date

Address: _____

Telephone: (____) _____ Fax: (____) _____