Housing Opportunities Commission
10400 Detrick Ave
Kensington, Maryland 20895-2484
(240) 627-9400
(301) 949-1433 FAX
RAinbox@hocmc.org

NOTE: If assistance is required to complete this form, please contact HOC staff at the location where you obtained the form or through the HOC address or phone numbers listed below.

REQUEST FOR REASONABLE ACCOMMODATION

HEAD OF HOUSEHOLD NAME: _____

TELEPHONE NO.: _____ **OTHER NO.:** _____

ADDRESS: _____

CITY, STATE, ZIP CODE: _____

PROGRAM (CIRCLE): **HOC RESIDENT** **VOUCHER PARTICIPANT**

NEW APPLICANT? ☐ YES ☐ NO

IF HOC RESIDENT, PLEASE PROVIDE HOC LEASE NUMBER: _____

1. The following member of my household has a disability, that is, a physical or mental impairment that substantially limits one or more life activities such as caring for one's self, doing manual tasks, walking, seeing, hearing, breathing, learning and/or working.

Name: _____

Relationship or association with you: _____

2. As a result of this disability, I am requesting the following reasonable accommodation: (Please complete one or more of the following sections):

HOC HOUSING RESIDENTS ONLY: I am requesting a change in my apartment or the public areas or commons areas of the housing development. The change and reason(s) for a change are described here (after completing, please go to question 3): _____

_____

_____

FOR ALL PROGRAM CLIENTS: I am requesting an exception to a rule, policy or procedure. The exception and reason(s) for the exception are described here (after completing, please go to question 3): _____

_____

_____

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Other Request (for example, a change in the way HOC communicates with you). Please specify (after completing, please go to question 3): _____

_____

_____

3. This request for reasonable accommodation is necessary so that I can: _____

_____

_____

4. I authorize HOC to verify that I have a disability and have the need for the reasonable accommodation I have requested. In order to verify this information the HOC may contact the following medical or mental health professional or service agency whose function is to provide services to persons with disabilities, or other expert:

Name: _____

Title: _____

Agency, Facility or Institution (if any): _____

Address: _____

City, State, Zip Code: _____

Telephone: _____

In addition, if applicable, I authorize HOC to contact the following individual who assisted me in the completion of this form:

Name: _____

Address: _____

City, State, Zip Code: _____

Telephone: _____

I understand that the information obtained by HOC will be kept completely confidential and will be used solely to make a determination on my reasonable accommodation request.

Signed: _____ Date: _____

Please return this form to the address listed above, and to the attention of **Compliance** as promptly as possible, so that HOC may make a determination on this request. This form may also be faxed to the attention of **Compliance** at 301-949-1433, or submitted via email to RAinbox@hocmc.org.

If you have questions regarding this form, please submit your inquiry via email, contact 240-627-9400 or Maryland Relay TTY at 711; or via mail to 10400 Detrick Avenue, Kensington, MD 20895. In addition, please sign the attached Health Provider's Verification of Need for a Reasonable Accommodation in Housing, ask your health provider(s) to complete it, and submit it to HOC along with this request.

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HEALTH PROVIDER'S VERIFICATION OF NEED FOR A REASONABLE ACCOMMODATION IN HOUSING

Applicant's Name: _____

Address: _____
(Street Address, City, State & Zip Code)

This is my authorization to release the information requested below.

Signature: _____ Date: _____

Dear _____:

As indicated in the attached Request for Reasonable Accommodation, the person named above is requesting a reasonable accommodation from the Housing opportunities Commission because of a disability.

He or she requests that you complete this form and return it to:

Housing Opportunities Commission
Compliance Department
10400 Detrick Avenue
Kensington, MD 20895
FAX: (301) 949-1433

I hereby certify, under the penalty of perjury, that the following statements are true and correct. False or fraudulent statements will be subject to the penalties provided by law.

1. I hereby certify that, in my professional medical opinion, the applicant for reasonable accommodation has a disability as defined below. Please check any paragraph below which applies:

☐ A. A physical or mental impairment that substantially limits one or more major life activities, such as caring for one's self, doing manual tasks, walking, seeing, hearing, breathing, learning and/or working.

☐ B. A record of having such an impairment.

☐ C. Is regarded as having such an impairment.

2. The disability is permanent:

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☐ **YES** ☐ **NO** ☐ **UNKNOWN**

3. If the disability is temporary, please explain:

_____

_____

_____

4. I hereby certify that the applicant's disability requires that one or more of the following accommodations needs to be made in order for the applicant to have equal opportunity to live successfully in HOC housing: (a) a fully accessible apartment or other physical modifications to the apartment or public/common areas, including assistive technology, (b) Reasonable accommodations to the rules and policies of the housing development, or HOC, as applied to applicant, or (c) assistance with communications with HOC.

Please respond to each of the following items.

A. Identify the accommodation(s) needed (if individual is requesting that HOC permit a live-in aide, please specify the nature of the assistance and the approximate number of hours of assistance each day the individual requires):

_____

_____

_____

B. Why the person needs the accommodation(s): _____

_____

_____

C. How is/are the accommodation(s) related to the disability: _____

_____

_____

_____

_____
_____
_____
_____
Name, address, and phone number of health provider

_____
Signature of health provider

_____
Date signed

Please return this form to the address listed above to the attention of **Compliance** as promptly as possible, so that HOC may make a determination on this request. This form may also be faxed to the attention of **Compliance** at 301-949-1433, or submitted via email to RAinbox@hocmc.org. Final decisions are made within 45 days, or less, after receipt of all requested documents.

Thank you. If you have questions regarding this form, please submit your inquiry via email, contact 240-627-9400 or Maryland Relay TTY at 711; or via mail to 10400 Detrick Avenue, Kensington, MD 20895.
(Este es un aviso importante. Por favor hágala traducir inmediatamente.)

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