The Housing Authority of Gloucester County
Administrative Offices
100 Pop Moylan Boulevard
Deptford, NJ 08096
Phone: (856) 845-4959 Fax: (856) 384-9044

REASONABLE ACCOMMODATION REQUEST/ VERIFICATION FORM

THIS SECTION IS TO BE COMPLETED BY THE HOUSING AUTHORITY OF GLOUCESTER COUNTY

(1) Name/Address of Program Applicant/Participant requiring accommodation/modification:

Name: _____

Address: _____

(2) Description of accommodation/modification being requested:

_____

THIS SECTION IS TO BE COMPLETED BY A QUALIFIED INDIVIDUAL*:

**A Qualified Individual can be a doctor or other medical professional, a peer support group, a non-medical service agency, a caseworker, a vocational/rehab specialist, counselor, or a reliable third party who is in a position to know about the individual's disability.*

Under federal and state law, an individual is disabled if he/she has a physical or mental impairment that substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such impairment. (See the Americans with Disabilities Act). Major life activities include walking, seeing, hearing, speaking, breathing, thinking, communicating, learning, performing manual tasks, and caring for oneself. Impairments also include such diseases and conditions as orthopedic; visual; speech and hearing impairments; Cerebral Palsy; autism; seizure disorder; Muscular Dystrophy; Multiple Sclerosis; cancer; heart disease; diabetes; HIV; mental retardation, mental and emotional illness; drug addiction; and alcoholism. This definition does not cover any individual who is a drug addict and currently using an illegal drug, or an alcoholic who poses a direct threat to property or safety because of alcohol use.

The individual listed above has identified him or herself as having a disability and has asked for a reasonable accommodation from this agency to meet certain needs dictated by the disability. When completing this Form do not disclose any medical diagnosis and do not attach or provide any medical records of the individual in support of this Form. Attached to this Form is a copy of an Authorization for the Release of Information executed by the individual.

(1) Does this individual have a disability, as defined above?

Yes___ No___ Unable to determine_____

(2) Does this individual, because of this disability, need an accommodation/modification in any rule, policy, practice, service, building or dwelling unit of the Housing Authority to afford him/her the opportunity to access housing, maintain housing, or fully use/enjoy housing? ("Need" indicates necessity as opposed to only a matter of convenience or preference).

Yes___ No___ Unable to determine_____

(3) If yes, please describe the accommodation/modification needed if different from the description under (2) of the first page of this Form.

_____

_____

_____

(4) Please explain the relationship or nexus between the requested accommodation and the individual's disability.

_____

_____

_____

(5) Please identify any alternate accommodations/modifications that may be implemented to achieve the same purpose.

_____

_____

_____

I certify that the information above is true and correct.

Signature: _____

Printed Name: _____

Date: _____

Professional Title:_____

Name of Clinic, Hospital, etc.: _____

Address: _____

Phone Number: _____ Fax Number: _____