

CHICOPEE HOUSING AUTHORITY

128 Meetinghouse Rd., Chicopee, MA 01013-1830

**¡Este documento es importante, tradúzcalo inmediatamente!
Dokiman sa a enpotan, tradui li tousuit!**

REASONABLE ACCOMMODATION REQUEST

Head of Household _____ (_____) _____
Phone

Requestor: _____
(Person Requesting Reasonable Accommodation, If Other Than Head of Household, Print Name)

Address _____ Resident No. _____

Signature _____
(Head of Household, Other Requestor, or Authorized Representative of Requestor)

A disability is defined, in part, as 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.

A Public Housing resident may request a change in his or her current unit or a transfer to a unit that has already been changed (in the resident's development or another development). An applicant, resident, or program participant may request assistance with, or change in, a Chicopee Housing Authority ("CHA") practice, rule, policy, procedure, program or service.

CHA will work with the applicant, resident or program participant to determine how to provide the reasonable accommodation request. CHA may require documentation to support the reasonable accommodation request(s).

1. The following is the name of the household member with a disability who needs a reasonable accommodation:

Name: _____

2. Because of the above household member's disability, the following change(s) or assistance (reasonable accommodation) is necessary so that the individual can participate in an CHA program as easily or successfully as other program participants.

Check the kind of change(s) you need.

- A change or special feature in a CHA dwelling, building or property.
- Assistance with, or change in, a CHA practice, rule, policy, procedure, program or service.



3. Describe the problem that the household member named in item 1 is having, or might have, with a CHA dwelling, building, property, practice, rule, policy, procedure, program or service:

4. Describe the type of change or assistance (reasonable accommodation) required:

5. Describe how this change or assistance will help with the problem:

6. Indicate the verification source CHA may contact to verify that the household member named in item 1 has a disability and needs a reasonable accommodation.

_____		_____
Name of Health Care Provider/Documenting Authority		Title

Company		
_____		_____
Address		Telephone Number

_____	_____	_____
City, State	Zip Code	Fax Number

Note: Individuals may obtain a copy of the CHA Reasonable Accommodation Policies and Procedures, upon request, from Public Housing Managers. You may also get additional copies of this request form from the Section 504 Coordinator:

Section 504 Coordinator
128 Meetinghouse Rd.
Chicopee, Massachusetts 01013-1830
Phone: (413) 592-6132 Ext. 123 Fax: (413) 594-7750
reasonableaccommodation@chicopeehousing.org

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REASONABLE ACCOMMODATION AUTHORIZATION FOR RELEASE OF INFORMATION

RE: Household member with disability:

I hereby authorize the release of information to Chicopee Housing Authority (CHA) regarding the request for reasonable accommodation described on this form. This release shall constitute a limited authorization for the release of information, as described below.

I hereby authorize to consult with representatives of CHA, in writing, in person, or by telephone concerning the physical or mental impairment(s) that I assert to qualify as an individual with a disability for the sole purpose of this reasonable accommodation request.

For purposes of this Release, a “Qualified Individual with a Disability” is defined as a person who has a physical or mental impairment that:

1. Substantially limits one or more major life activities
2. Has a record of such an impairment
3. Is regarded as having an impairment

“A Physical or Mental Impairment” is defined as:

1. Any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the body systems including, but not limited to: neurological, musculoskeletal, special sense organs, respiratory, and speech organs or
2. Any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness and specific learning disabilities.

The term “Physical or Mental Impairment” includes, but is not limited to, such diseases and conditions as visual, speech and hearing impairments, epilepsy, multiple sclerosis, cancer, etc.

“Major Life Activities” include functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.

“Has a Record of Such an Impairment (mental or physical)” means has a history of, or has been misclassified as having, a mental or physical impairment that substantially limits one or more major life activities.



“Is Regarded as Having an Impairment” means:

1. Has a physical or mental impairment that does not substantially limit one or more major life activities but is treated by a recipient as constituting such a limitation.
2. Has a physical or mental impairment that substantially limits one or more major life activities only as a result of the attitudes of others toward the impairment.
3. Has none of the impairments defined by Section 504's definition of “physical or mental Impairment” but is treated by a recipient as having such an impairment.

In addition, I authorize _____ to provide only documentation that is necessary to verify that I meet the definition of a “Qualified Individual with a Disability”, as defined above.

This Authorization solely authorizes the release of information necessary to verify the following:

1. Documentation necessary to verify that the person meets the definitions noted above;
2. A description of the needed accommodation; and,
3. A description of the identifiable relationship between my disability and the requested accommodation(s).

This Authorization for Release of Information should only seek information that is necessary to determine if the requested reasonable accommodation is needed because of a disability.

This Authorization does **not** authorize CHA to examine my medical records, including diagnosis or test result(s); nor does this authorize the release of detailed information about the nature or severity of my disability.

The information/documentation released as a result of this Authorization shall be kept confidential and not shared with anyone unless required to make or assess a decision to grant or deny a reasonable accommodation request.

Name of Family Member/Parent/Legal Guardian [Print]

Relationship to Person with Disability

Signature

Date

PLEASE PROVIDE THE FOLLOWING INFORMATION:

Name of Health Care Provider/Documenting Authority

Title

Company

Address

Telephone Number

City, State

Zip Code

Fax Number

REASONABLE ACCOMMODATION VERIFICATION

Head of Household (Print name) Resident No.

Re: Reasonable Accommodation Request

For: _____
(Print name of household member for whom the request is being made) Telephone No.

Please return to:

(CHA employee name) CHA Phone: (413) 592-6132

Chicopee Housing Authority
128 Meetinghouse Rd.
Chicopee, Massachusetts 01013-1830

The Follow Section is to Be Filled Out by The Designated Verification Source:

1. The individual seeking an accommodation is a person with a disability according to the following definition: "Disability" is defined as a physical or mental impairment that substantially limits one or more major life activities; a record of having such impairment or being regarded as having such impairment.

YES NO

2. Describe the problem(s) that the person is having with the CHA dwelling, building, property, practice, rule, policy, procedure, program or service:

3. Do(es) the person(s) making the reasonable accommodation meet the definition of disability as mentioned in 1. Above?

4. Describe the type of change(s), feature(s) or assistance required:

5. Please describe the relation between the person's functional limitation(s) and the requested accommodation. Do not provide unnecessary details about the medical history or disabled status of the person seeking an accommodation.

Name of Verification Source

Title

Company

Signature

Address

Telephone Number

Fax