



1805 Harrison Street, Oakland, CA 94612

Request for Reasonable Accommodation

Date of Request: _____

Name of Resident or Applicant: _____	Client #: _____		
Address: _____	City: _____	State: _____	Zip: _____
Phone Number: _____	Message Number: _____		

1. The following household member, _____, has a disability as defined below:
A physical or mental impairment that limits one or more of the person's major life activities (e.g., caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working); and has a record of having, or being perceived as having, a physical or mental impairment. It does not include current illegal use of, or addiction to, a controlled substance

2. Reasonable accommodation requested: **Example: Live-in aide, additional bedroom/increase in subsidy.**

3. Reason for requesting this accommodation: **(Why is this accommodation needed?)**

4. List the name of your doctor, health care provider or other qualified individual who can verify the request:
Name: _____ Title _____
Address: _____
Phone: _____ Fax Number: _____

The verification form is printed on the back of this request for your convenience.

If you have any questions about completing this form, please contact:

Oakland Housing Authority Representative Phone _____ Number _____

Reasonable Accommodation Verification

Important: This independent verification is to be completed by a doctor, licensed professional representing a rehabilitation center, or the supervisor or case manager representing a disability agency.

Name of Patient: _____ Medical Record Number: _____

Address: _____ Telephone Number: (____) _____

City/State/Zip: _____

I authorize the release of information, relative to my physical or mental impairment, in order to verify the reasonable accommodation I have requested on the backside of this form.

Signature: _____ Date: _____

The Oakland Housing Authority is required by law to provide reasonable accommodations to disabled applicants, residents, and participants that will facilitate their ability to function and provide equal opportunity to use and enjoy our housing programs. Applicable Federal and state law defines "disability" with respect to the individual as (1) a physical or mental impairment that limits one or more of the person's major life activities (e.g., caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working); (2) having a record of having, or being perceived as having, a physical or mental impairment. It does not include current illegal use of, or addiction to, a controlled substance. _____ has been my patient since ____/____/____.

(Patient's Name)

Due to his or her disability, the patient has the following functional limitations:

and requests that the Oakland Housing Authority provide the following reasonable accommodation(s) to give equal access to housing. An explanation of why the accommodation(s) is needed below: *(Use additional sheets if necessary.)*

A. Physician or licensed professional, please explain the relationship between the accommodation and the disability (why the accommodation is necessary to assure equal access to housing).

B. The patient requires [] permanent [] short-term accommodation; if it is for short-term accommodation, please specify the duration required: _____ months/years

C. [] In my professional assessment, the patient's disability **does not** justify the accommodation requested.

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

Physician's Signature

Date

Print Name and Title

Medical License Number

Address Phone

Number

Section 1001 of Title 18 of the US Code makes it a criminal offense to make any willful false statements or misrepresentations to any Department or Agency of the United States as to any matter within its jurisdictions, punishable by fine not to exceed \$250,000 and or imprisonment of not more than 5 years.