

WEST VALLEY HOUSING AUTHORITY  
 204 SW WALNUT  
 DALLAS, OR 97338  
 (503) 623-8387

<u>- OFFICE USE ONLY -</u>	
NAME OF FAMILY	STAFF INITIALS
<b>PROGRAM-SPECIFIC INFO:</b> Please a check (T) in the appropriate box that relates to the family's status:	
<input type="checkbox"/> LRPH Applicant	<input type="checkbox"/> Section 8 Applicant
<input type="checkbox"/> LRPH Resident	<input type="checkbox"/> Section 8 Participant

**REQUEST FOR REASONABLE ACCOMMODATION**

\_\_\_\_\_  
Date of Request

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Name of Applicant/Tenant

Address	City	State	Zip Code
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1. Please **indicate the name of the disabled household member** who is requesting the accommodation: \_\_\_\_\_

2. Please **describe the reasonable accommodation** you are requesting: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

3. Please **explain the reason you are requesting this accommodation** and how it will provide you with equal opportunity to enjoy our housing programs, your unit and/or common areas: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**On Page 2, you will find the Verification of Disabled Status portion of your request. Please take the entire form to someone (a doctor, counselor, health care provider, etc.) who can verify your need for this reasonable accommodation. Upon receipt of the completed form, we will let you know our decision as soon as possible or whether additional information is needed in order to make a decision.**

If you need assistance with this form or have any additional questions, please contact the Housing Authority at (503) 623-8387. Please return the completed form to the Housing Authority at P.O. Box 467, Dallas, OR 97338. We can also be contacted, via TDD, by calling 1(800) 735-2900.

**I hereby authorize the release, to West Valley Housing Authority, of any information that would be helpful in making a determination on my above-noted request for reasonable accommodation. I also certify that the above information is true to the best of my knowledge and I am hereby requesting reasonable accommodation as outlined above.**

\_\_\_\_\_  
Signature of Applicant/Tenant

\_\_\_\_\_  
Date

**“VERIFICATION OF DISABILITY STATUS”  
FOR REASONABLE ACCOMMODATION**

TO: \_\_\_\_\_

RE: \_\_\_\_\_

State and federal laws require housing providers to make reasonable accommodations or changes to either the apartment, other parts of the housing complex, or to house rules/policies/procedures (not essential terms of the lease) if such changes are necessary to enable a person with a disability to have equal access and enjoyment of the apartment and other facilities or programs at the site. Please note that such changes must be necessary for the person have equal access and enjoyment of the housing program — **not just desirable.**

The applicant/ tenant in question has requested the accommodation described in Page 1. Please indicate whether you believe the family member identified has a disability as noted. Please indicate below whether the accommodation is necessary and will achieve its stated purpose. You may also add any other information that would be helpful in making the correct accommodation for this person. This form **should not** be used to discuss the person’s diagnosis or any other information that would not be directly relevant to the request for their accommodation.

Please note that the applicant/tenant has signed this form requesting you to answer the questions. If you have any questions, please call Frank Friel, Section 8 and Occupancy Manager, at (503) 623-8387, Ext. 28.

Thank you.

**THIS SECTION IS TO BE COMPLETED BY THE  
HEALTHCARE OR SOCIAL SERVICE PRACTITIONER ONLY**

In my professional opinion, \_\_\_\_\_  **does**  **does not** meet the definition of a “person with a disability” for purposes of non-discrimination and the right to reasonable accommodation. The laws define those terms as a person who: (1) has a physical or mental impairment that substantially limits one or more major life activities; (2) has a record of such impairment; or (3) is regarded as having such an impairment. “Major life activity” includes caring for one’s self, performing manual tasks, walking, seeing, hearing, breathing, learning and/or working.

In my professional opinion, I  **do**  **do not** believe that the accommodation requested on Page 1 will provide the tenant/applicant with equal opportunity to use and enjoy their housing.

In my professional opinion, I  **do**  **do not** believe that the named tenant/applicant is limited by their disability from performing the noted tasks.

**OTHER COMMENTS:**  
(Please attach additional forms if needed.)

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\_\_\_\_\_  
Signature of Healthcare or Social Service Practitioner

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name / Professional Title

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Address City State Zip

Please return this form to West Valley Housing Authority, PO Box 467, Dallas, OR 97338.

**NOTE:** 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 jurisdiction.