

APPLICANT RELEASE FORM FOR THIRD PARTY REASONABLE ACCOMMODATION VERIFICATION and VERIFICATION QUESTIONNAIRE

(To be completed by client and authorized professional)

Section A

Name of Client: _____

Address: _____

Telephone: _____

Section B

Name and address of entity requesting authorized information:

City of Pensacola Housing Division

420 W. Chase St

P.O. Box 12910

Pensacola, FL 32521-0031

Telephone: (850) 858-0350

Section C: Purpose

Verification of disability and verification of whether the individual requires the requested accommodation / modification due to his or her disability.

The person listed above has applied for or is receiving housing assistance under a program of the U. S. Department of Housing and Urban Development (HUD) and the City of Pensacola Housing Division. Program regulations require the verification of all information that is used in determining eligibility or level of benefits for participants. We ask your cooperation in completing the attached questionnaire and returning it to the Housing Division. Your prompt return of this information will help to assure timely processing of the individual's request. The applicant has consented to this release of information as shown below.

Section D: Verifying Agency Information

Name of person/agency authorized to disclose information: _____

Address: _____

Telephone: _____

Section E: Client Authorization

I hereby understand and acknowledge:

- That I had an opportunity to read and understand the contents of this authorization and I agree that, by signing this form, I am authorizing the referenced person(s) or agency to complete the attached questionnaire.
- That the completion of the attached questionnaire is required to determine if my request for reasonable accommodation is necessary for me to take full advantage of the housing program.
- That the information obtained under this consent is limited to information obtained within the past twelve (12) months.
- That the agency and person(s) listed above have knowledge of whether my disability requires a reasonable accommodation or modification. To verify an accommodation or modification, a request may be made from the verifying agency for only the minimum information necessary to confirm that such accommodation or modification is required. Any other request for information about me is not relevant and may not be made (e.g. diagnosis; treatment).
- This authorization will expire one year from the date it is signed.
- I am entitled to a copy of this authorization after I sign it.

Signature of Head of Household

Date

Signature of Other Family Member (if not minor child or dependent)

Date

If you are signing as Power of Attorney, Legal Guardian, Executor, or Administrator complete the following and submit a copy of the legal documents.

Personal Representative's Name

Relationship to Client

SECTION F: CLIENT'S REQUEST

A "reasonable accommodation" is a change, exception, or adjustment to a rule, policy, practice or service that may be necessary for a person with a disability to have an equal opportunity to use and enjoy a dwelling, including public and common-use spaces. Since rules, policies, practices and services may have a different effect on persons with disabilities than on other persons, treating persons with disabilities exactly the same as others will sometimes deny them an equal opportunity to use and enjoy a dwelling. (Joint Statement of the Departments of HUD and Justice: Reasonable Accommodations under the Fair Housing Act). Examples of a reasonable accommodation could include, but are not limited to, providing a dedicated handicap parking space, allowing a service animal, or authorizing a live-in aide.

INSTRUCTIONS TO CLIENT: Describe what you are requesting to enable full enjoyment of the Housing Choice Voucher program. (For example: larger voucher size, accessible unit, ground floor unit, companion animal):

SECTION G: DEFINITION OF A PERSON WITH A DISABILITY

Under federal fair housing law and Section 504 of the Rehabilitation Act, 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 an impairment; or is regarded as having such an impairment.

The term physical or mental impairment includes, but is not limited to such diseases and conditions as orthopedic, visual, speech, and hearing impairments, cerebral palsy, autism, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, Human Immunodeficiency Virus infection, emotional illness, drug addiction, and alcoholism. However, this definition does not include any individual who is a drug addict and is currently using illegal drugs or an alcoholic who poses a direct threat to property or safety because of alcohol use [24 CFR Part 8.3 and HUD Guidebook 7420.10, (Chapter 5, Page 5-44)].

SECTION H: REASONABLE ACCOMMODATION VERIFICATION QUESTIONNAIRE

(To be completed by the verifying professional or agency)

1. Is the household member disabled as defined above? Yes _____ No _____

2. How are you associated with the household member? _____

3. How long have you been treating the household member? (Please do not include specific details of treatment.)

4. Are you a medically licensed and/or certified professional in the state of Florida? If not, please provide the state where you are medically licensed and/or certified.

5. Please provide your professional credentials that support your ability to treat and/or provide services to persons with disabilities.

6. Does the household member require what he or she has requested as a reasonable accommodation or modification for the household member's disability:

Yes _____ No _____

7. Please describe how the requested accommodation or modification will enable the household member full enjoyment of the voucher program or unit. (Attach additional sheets if necessary.)

SECTION H: REASONABLE ACCOMMODATION VERIFICATION QUESTIONNAIRE, CONTINUED

(To be completed by the verifying professional or agency)

8. In your medical opinion, is there any other accommodation or modification that could meet the household member's needs in place of what the household member has requested? For example, if there is an alternative way to enable the household member full enjoyment of the unit, please detail it.

9. Are there any negative consequences that the household member would be subject to if the household member were not able to receive the specific accommodation or modification requested?

SECTION I: THIRD PARTY SIGNATURE

By signing below, I verify that I am a medical and/or certified health professional licensed for such work by the State in which I practice. The person listed on this form is a current, within the last twelve months, patient or client of my practice and I am qualified to render diagnosis of this patient or client's needs.

Name and Title

Name of Firm / Agency

Signature

Telephone

Date

PLEASE RETURN FORMS TO:

**City of Pensacola
Housing Division
P.O. Box 12910
Pensacola, FL 32521-0031
(Physical address: 420 W. Chase St)
(850) 858-0350**

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

Pensacola Housing Division, 420 W. Chase Street
P.O. Box 12910., Pensacola, FL 32521-0031
Telephone: 850-858-0350
Fax: 850-595-0113
www.cityofpensacola.com/housing

