Housing Authority of the County of San Mateo
264 Harbor Blvd., Bldg. A
Belmont, CA 94002-4017
Fax: (650) 802-3372
rasubmissions@smchousing.org

FOR PHA USE ONLY
☐ Request Approved ☐ Request Denied
Comments: _____
_____
Supervisor Signature: _____
Date:

REQUEST FOR A REASONABLE ACCOMMODATION
(To be completed by program participant)

NOTE: This form is to be completed and signed by the Head of Household on behalf of the Household Member needing the accommodation. Please complete a separate "Request for a Reasonable Accommodation" form for each Household Member requiring an accommodation.

If the disabled Household Member who needs the accommodation is 18 years of age or older, he or she **AND** the Head of Household must sign this form.

Head of Household

Name: _____ Last four digits of SSN#: XXX-XX-_____

Phone: _____ E-mail: _____

Address: _____

1. The following household member, _____, has a disability as defined below:

   A physical or mental impairment that substantially limits one or more major life activities (e.g., caring for one's self, walking, seeing, hearing, speaking, and breathing); a record of having such an impairment; or being regarded as having such an impairment.

2. Place a check (✓) in the box that best describes the accommodation you are requesting.
   ☐ Live-in aide ☐ Additional bedroom/increase in voucher size ☐ Relocate to a different county/portability
   ☐ Rent from a relative: Relative Name: _____ Relationship: _____
   ☐ Other: If none of the above are applicable, describe the accommodation you are requesting:
   _____

3. Describe why this accommodation is needed and how it relates to a disability *(Please attach an additional page if more space is needed):*

4. Provide contact information for the individual who can verify the disability and the need for the accommodation requested. This should be the individual providing professional services that relate to the disability.

Name: _____ Position/Title: _____

Phone: _____ Fax/E-mail: _____

Business Name: _____

Business Address: _____

Authorization to Release Information: I/We authorize the care provider listed above to disclose relevant information to the Housing Authority of the County of San Mateo regarding the need for a reasonable accommodation. I understand the information the Housing Authority obtains will be kept confidential and used solely to determine if an accommodation should be provided.

Signatures: Head of Household: _____ Date: _____

Other Adult (if needed): _____ Date: _____