

**REASONABLE ACCOMMODATION  
REQUEST & VERIFICATION PACKET**

To Whom It May Concern,

We acknowledge your intent to request a Reasonable Accommodation. To process your request, we need third-party verification of your disability-related need. Please know, that New Britain Housing Authority (NBHA) never makes inquiries into the nature or extent of your disability. The NBHA does need verification that your request is related to your disability and removes a barrier you face to housing.

Once we receive the completed verification form back from your third-party verifier, we will review your request. **Please return the third-party verification of your disability-related need within 15 days from the date of this letter.**

**Please note: If your reasonable accommodation request is not returned, your application will become inactive, meaning you will not be eligible for your requested reasonable accommodation until the required information is received by the Supervisor of Public Housing or the Housing Choice Voucher Program.**

If you have any questions, you may contact your  
Tenant Selection Interviewer \_\_\_\_\_ at 860-225-3534 Ext. \_\_\_\_\_.

**I am requesting the following as a Reasonable Accommodation:**

(List your reason for the reasonable accommodation here)

I, \_\_\_\_\_, acknowledge that I have received a Reasonable Accommodation Form and understand that my Third Party Verifier must complete and return this Form in order to be eligible to receive a reasonable accommodation.

\_\_\_\_\_  
**Applicant's Signature**

\_\_\_\_\_  
**Date**

NAME OF APPLICANT/PARTICIPANT \_\_\_\_\_

**REQUEST FOR A REASONABLE ACCOMMODATION  
RELEASE OF INFORMATION FORM**

**Instructions (please review carefully)**

- (1) The individual or family member should check off the boxes and fill out the blanks as appropriate regarding their request(s).
- (2) The third party professional (such as a doctor/nurse, social worker, or service agency counselor) initials the corresponding selection, if the checked item in the professional's opinion, is needed due to the individual's or family member's disability. Attach supplemental information if necessary for any requests. Do not include any information about the nature or extent of the person's disability. **DO NOT SEND MEDICAL RECORDS.**
- (3) The third party professional "MUST" complete and sign the form as directed.
- (4) All requests with complete verification documents will be responded to within 30 days of receipt of the completed documents. If the request is denied information will be provided on the right to grieve the denial.
- (5) Please note: this form should be returned within 15 days from the date the requester received it.

**Please Complete Release of Information:**

Applicant/Participant \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(Print the name of the person with the disability)

I currently reside at \_\_\_\_\_

My phone # \_\_\_\_\_ Name of the Head of Household \_\_\_\_\_

By signing this release, I authorize \_\_\_\_\_  
(Name of Third Party Professional, i.e. nurse, social worker, doctor)

to release information to the NBHA to verify my disability and the need for an accommodation.

Applicant/Participant/Guardian (sign name) \_\_\_\_\_ Date: \_\_\_\_\_

*\*If this is for a child with disabilities please print Guardian's name \_\_\_\_\_  
and Guardian should sign above.*

**If you are in need of additional assistance or an alternate means of reviewing and understanding this process, please contact the HCV Supervisor at 860-225-3534, Ext. 218. 16 Armistice Street, New Britain, CT 06053. Fax 860-827-4615.**

NAME OF APPLICANT/PARTICIPANT \_\_\_\_\_

**SPECIAL ACCOMMODATIONS NEEDED  
FOR PROFESSIONAL TO COMPLETE**

\_\_\_ Extra time to locate a unit due to disability related reasons. (Please explain why additional time to find a unit is needed due to the person's disability.) **Professional Initial Here:** \_\_\_\_\_

\_\_\_ Assistance to locate an apartment is needed because of a disability. (Please explain why assistance is needed due to the person's disability.) **Professional Initial Here:** \_\_\_\_\_

\_\_\_ Additional utility allowance **Professional Initial Here:** \_\_\_\_\_  
(for medical equipment that uses extra electricity)

Specify equipment \_\_\_\_\_

\_\_\_ Extra bedroom for equipment (specify equipment) **Professional Initial Here:** \_\_\_\_\_

\_\_\_ Special accommodations for visual impairments **Professional Initial Here:** \_\_\_\_\_  
(Please specify format; example: Large Print)

\_\_\_ Special communication needs for the deaf/hard of hearing. **Professional Initial Here:** \_\_\_\_\_

- Sign Language Interpreter
- Other \_\_\_\_\_

\_\_\_ Other (explain). **Professional Initial Here:** \_\_\_\_\_

\_\_\_ **EXTRA BEDROOM FOR LIVE-IN AIDE:** This individual requires LIVE-IN assistance related to disability not just visiting help. This is not verification for aides who come & go such as a caregiver that works specific shifts during the day or night on a regular basis. A live-in aide must meet this HUD definition: A live-in aide is a person who resides with one or more persons with disabilities and who: (1) Is determined to be essential to the care and well-being of the person(s); (2) Is not obligated for the support of the person(s); and (3) Would not be living in the unit except to provide the necessary supportive services.

**Please describe the duties of your aide below.** **Professional Initial Here:** \_\_\_\_\_

NAME OF APPLICANT/PARTICIPANT \_\_\_\_\_

**FOR PROFESSIONAL TO COMPLETE**

In my professional opinion, the above individual:

a) has a disability as defined below which creates a barrier to access NBHA housing/housing assistance and related programs and services,

and

b) the requested special features, modifications, and/or change(s) to NBHA policy(s) listed above are required to address those barriers in order to allow the above individual full access to NBHA housing and related programs and services.

*The Fair Housing Act defines a person with a disability as:*

- (1) individuals with a physical or mental impairment that substantially limits one or more major life activities;*
- (2) individuals who are regarded as having such an impairment; and*
- (3) individuals with record of such an impairment.*

Name (print): \_\_\_\_\_ Title: \_\_\_\_\_

Organization Name and Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Person to contact with questions about form: \_\_\_\_\_

**I certify that the information I am providing is accurate and true to the best of my knowledge based on my professional training and experience.**

Signature of Professional: \_\_\_\_\_ Date: \_\_\_\_\_

-----  
The certifying professional should return this form to: Interviewer \_\_\_\_\_

Fax Number: 860-827-4615 or

Email: \_\_\_\_\_@nbhact.org

**Note: It is important that all 4 pages need to be completed and returned within 15 days from the date the requester received them.**

**For NBHA Office Use Only**

Interviewer Name: \_\_\_\_\_ Date R.A. Verified \_\_\_\_\_

Date Request Entered Into R.A. Log: \_\_\_\_\_ Supervisor Approval: \_\_\_\_\_