



Reasonable Accommodation (504) Request/Verification Form

To be Completed by the Applicant or Tenant		
Please select one of the following that describes the nature of your request ☐ HCV Participant ☐ PBV Referral ☐ Waitlist Applicant		Date of Request
Applicant or Tenant Name:		
Street Address		
City	State	ZIP
Email	Phone	

CMHA makes reasonable adjustments to its rules, policies, practices, or services when such accommodations are necessary to afford a tenant or applicant with a physical or mental disability the equal opportunity to use and enjoy a dwelling unit, including public and common use areas, including the use of service animals.

(a) who has a physical and/or mental impairment that substantially limits one or more major life activities and is a person who has a history or record of such an impairment or a person who is regarded as having such an impairment. (i) As used in this definition, “a physical and/or mental impairment” includes any physiological disorder or condition, cosmetic disfigurement, anatomical loss, and any mental or psychological disorder. (ii) “Major life activities” includes functions such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working. (b) Disabilities do not have to be permanent or have existed for a period before a reasonable request is made.

If the requested accommodation is for a household member who is not the Head of Household, please identify them here:

Requested Accommodation:

By signing this form, I authorize the health care provider listed on the form below to provide CMHA with information to make a decision regarding my request for a reasonable accommodation.

Applicant or Tenant Signature

Date

If you are requesting an additional bedroom for medical equipment, your medical provider must specifically describe the equipment and the approximate size of the equipment. Any request that does not provide this information will be returned to the medical provider for further processing and/or denied.

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COLUMBUS METROPOLITAN HOUSING AUTHORITY

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Note: If this page has not been completed, your request may be denied. If the following page has not been completed and received within (30) calendar days of the date of the provider letter, the requested accommodation may be denied.

Message to the Health Care Provider

DO NOT attach any medical records or other documentation regarding the individual's disability. You must address these issues in your responses to the questions below. CMHA cannot and will not interpret documentation regarding an individual's disability to determine if their disability requires the requested accommodation. As the Health Care Provider, it is your responsibility to provide the necessary information regarding the individual's disability and how that disability is related to their Request for Accommodation

Verification Questionnaire (Completed by the Health Care Provider)

The tenant or applicant identified has requested a reasonable accommodation from CMHA. So that CMHA can process this request, please answer the following questions and return this completed form to CMHA.

- | | |
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| 1) Is the individual identified above as disabled, as the term has been defined above? | ☐ Yes ☐ No |
| 2) Is this individual under your care as a health care provider? | ☐ Yes ☐ No |
| 3) Under your health care, have you seen this individual in the last 12 months? | ☐ Yes ☐ No |
| 4) How long have you been treating this individual? In your response, please do not include details of the treatment. | |
| 5) Please state your professional credentials that support your ability to assess whether the individual has a disability. | |
| 6) Does the Applicant or Tenant have a disability that request a Reasonable Accommodation? ☐ Yes ☐ No
If yes, please describe how the requested accommodation will enable the individual equal opportunity to use and enjoy a dwelling unit, including public and common areas. There must be an identifiable relationship, or nexus, between the requested accommodation and the individual's disability. Please only provide information that is necessary to evaluate the disability-related need for this accommodation. The nature or extent of the disability is not required. | |

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7) The 504 Reasonable Accommodation will provide health and/or supportive care services as follows (if requesting a second bedroom for medical equipment, including approximate physical dimensions of required medical equipment):

8) The Reasonable Accommodation(s) requested above (please select one):

- ☐ Would be helpful/beneficial to this person.
- ☐ Is/Are a necessity/essential/required for this person (i.e., without this accommodation, this person will be prevented from participation in CMHA's programs).
- ☐ I do not have enough information or personal knowledge to choose either of the above options.

I hereby certify that all the information that I provided in this form is accurate, complete and current. I understand that I can be subpoenaed to testify in any trial or hearing related to the applicant or tenant's request. I also acknowledge that Section 1001 of Title 18 United States Code, make it a criminal offense to make a knowing and willful false statement to any department or agency of the United States as to any matter within its jurisdiction, punishable by a fine not to exceed \$250,000.00 and/or imprisonment of not more than 5 years.

Health Care Provider's Name (Please print clearly)

Street Address

City

State

ZIP

Phone

Fax

Health Care Provider Signature (Please sign with blue ink)

Date

Please return this completed form and address any questions or updates to:

504 Reasonable Accommodation Coordinator

Columbus Metropolitan Housing Authority

880 E. 11th Avenue

Columbus, OH 43211-2771

Email (preferred): 504accom@cmhanet.com

Fax: 614-421-4516