Miami-Dade CoC TBRA Program

REQUEST FOR REASONABLE ACCOMMODATION
DUE TO RESIDENTIAL TREATMENT, REHABILITATION OR CARE OR HOSPITALIZATION

PARTICIPANT NAME: _____
SOCIAL SECURITY NUMBER: _____
TELEPHONE NO.: _____
CITY, STATE, ZIP CODE: _____

I hereby request reasonable accommodation of, or exception to, the Miami-Dade CoC TBRA Program Policies and Procedures prohibiting absence from my assisted housing for more than thirty days due to my need for residential treatment, care or hospitalization. I understand that such absence may not exceed ninety (90) days.

1. **Please describe facility:**

   ☐ Residential treatment, rehabilitation or care facility
   ☐ Hospital

2. **Anticipated length of stay or hospitalization**: _____

3. **Describe any other requested accommodation or exception to program policy or procedure in addition to the request for an extended absence:**

   _____

   _____

   _____

   _____

4. **Client Authorization for Verification and Discharge Coordination:**

   I authorize the Miami-Dade County Homeless Trust and its contracted TBRA Provider _____ (TBRA Provider) to verify my need for residential treatment, rehabilitation or care or hospitalization and the need for the reasonable accommodation I have requested.

   In order to verify this information, the Miami-Dade County Homeless Trust and the TBRA Provider may contact the behavioral or health provider named below and I consent to such provider disclosing information regarding my medical, mental health, substance abuse history, diagnosis, including diagnosis of HIV/AIDS, condition and/or treatment for the above-stated purpose of verification and for discharge coordination to the Trust and TBRA Provider.

   Name: _____
   Title: _____
   Agency, Facility or Institution (if any): _____
   Address: _____
   City, State, Zip Code: _____
   Telephone: _____

In addition, if applicable, I authorize the Miami-Dade County Homeless Trust and the TBRA Provider to contact the following individual who assisted me in the completion of this form if it is someone other than my TBRA Housing Specialist or Case Manager:

Name: _____
Address: _____
City, State, Zip Code: _____
Telephone: _____

I understand that the information obtained by the Miami-Dade County Homeless Trust and the TBRA Provider will be kept completely confidential and used solely to make a determination on my reasonable accommodation request.

Signed: _____ Date: _____
(Participant or Authorized Representative)

Print Name: _____

Please request that your provider: (1) attach a letter on its own letterhead and signed by an authorized representative that verifies the need for residential treatment, rehabilitation or care or hospitalization and the anticipated length of stay and (2) mail it, along with your Request for Reasonable Accommodation (this form), directly to your TBRA Housing Specialist or Case Manager as follows:

MAIL TO:

Name: _____
Title: Housing Specialist or Case Manager
Agency: _____
Address: _____
_____
Telephone: _____

(2019)