Miami-Dade CoC TBRA Program

REQUEST FOR REASONABLE ACCOMMODATION

(If assistance is required to complete this form, please contact your TBRA Housing Specialist or Case Manager)

Applicant/Participant: _____
Social Security Number: _____
Telephone: _____
Address: _____

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1. I have, or the following member of my household has, a disability, *i. e.,* a physical or mental impairment that substantially limits one or more life activities such as caring for one's self, doing manual tasks, walking, seeing, hearing, breathing, learning and working.

   Name:_____

   Relationship or association with you: _____

2. As a result of this disability, I am requesting the following reasonable accommodation (please feel free to attach sheets if needed):

   a. Please specify the accommodation requested and, if applicable, any exception to a TBRA Program rule, policy or procedure.

   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____

   b. This request for reasonable accommodation is necessary so that I or my household member can: (Please specify.)

   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____

4. I authorize the Miami-Dade County Homeless Trust and its contracted TBRA provider _____ (TBRA Provider) to verify that I or my household member have a disability and have the need for the reasonable accommodation I have requested. In order to verify this information, the Miami-Dade County Homeless Trust and its TBRA Provider may contact the following medical or behavioral health professional, or licensed service agency whose function is to provide services to the disabled, or other expert in the field of:

   _____

   Name: _____

   Title of Professional or Expert: _____

   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 its TBRA Provider to contact the following individual who assisted me in the completion of this form:

   Name: _____

   Address: _____

   City, State, Zip Code: _____

   Telephone: _____

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

Signed: _____ Date: _____
(Head of household or Authorized Representative)

Signed: _____ Date: _____
(Individual with the Disability if Over 18)

Please sign, or have your household member sign, the <u>attached</u> Health Provider's Verification of Need for a Reasonable Accommodation in Housing Because of a Disability <u>and</u> request that the Health Provider mail it, along with your Request for Reasonable Accommodation (this form), directly to your TBRA Housing Specialist or Case Manager.

If you have any questions regarding this form, please contact your TBRA Housing Specialist or Case Manager. You may also contact a Miami-Dade County Homeless Trust Housing Specialist at (305)375-1490. Note that incomplete forms will be rejected.

HEALTH PROVIDER'S VERIFICATION OF NEED FOR A REASONABLE ACCOMMODATION BY THE MIAMI-DADE CoC TENENT-BASED RENTAL ASSISTANCE (TBRA) PROGRAM BECAUSE OF A DISABILITY

Person Requesting Program Accommodation Name:_____

Social Security Number: _____

Address: _____
(Street Address, City, State & Zip Code)

This is my authorization to release the information requested below to the Miami-Dade County Homeless Trust and its contracted TBRA provider, _____.

_____ _____
Signature of Household Member Requesting Accommodation: **Date**

_____
Print Name

For Professional's Use

As indicated in the attached Request for Reasonable Accommodation, the person named above is requesting a reasonable accommodation from the Miami-Dade CoC TBRA Program because of disability. Disability is defined as a physical or mental impairment that substantially limits one or more life activities such as caring for one's self, doing manual tasks, walking, seeing, hearing, breathing, learning and working.

Such person requests that you complete this form and return it to:

_____
(Name of TBRA Housing Specialist or Case Manager)

_____
(Name of Miami-Dade CoC TBRA Provider)

_____
(Mailing Address of TBRA Provider)

Please answer completely and in detail the following:

1. The disability is permanent. [ ] **YES** [ ] **NO** [ ] **UNKNOWN**

2. If the disability is temporary, please explain: _____
_____
_____

3. Please describe the nature of the disability:

_____
_____
_____
_____
_____

4. In my opinion, the applicant's disability requires that one or more of the following accommodations needs to be made in order for the applicant to have equal opportunity to participate in the HOPWA Program: (a) reasonable accommodations to the rules and policies of the HOPWA Program, as applied to applicant, (b) assistance with communications with the Program; or (c) other (describe) _____.

[ ] YES (Please respond to each of the following questions.)
[ ] NO (please go to the end of this page, read the certification and sign bottom of the document).

a. The accommodation(s) needed: _____
_____
_____
_____

b. Why the person needs the accommodation(s): _____
_____
_____
_____

c. How the accommodation(s) is/ are related to the disability:_____
_____
_____
_____

d. How the accommodation(s) will assist the person to participate in the Rental Housing Assistance Program:
_____
_____
_____
_____

I HEREBY CERTIFY UNDER PERJURY OF LAW THAT I UNDERSTOOD THE QUESTIONS ASKED HEREIN AND THAT ALL INFORMATION I PROVIDED IN THIS REQUEST IS ACCURATE, COMPLETE, AND CURRENT.

_____ _____
Signature of Health Provider Date

Print Name: _____

Fla. License No._____

Thank you. If you have any questions, please contact your patient's TBRA Housing Specialist or Case Manager. You may also contact a Miami-Dade County Homeless Trust Housing Specialist at (305)375-1490. Note that incomplete forms will be rejected.