WASHINGTON COUNTY HOUSING AUTHORITY

100 S. Franklin Street
Washington, Pennsylvania 15301
TDD Number: 724-228-6083
Office Number: 724-228-6060
Main Fax Number: 724-228-6089
Accounting Dept. Fax Number: 724-228-8685
Purchasing Dept. Fax Number: 724-228-6154
www.wchapa.org • Email: wcha@wchapa.org

REASONABLE ACCOMMODATION REQUEST PACKET

Applicants and Housing Choice Voucher Program Participants

PURPOSE

This packet helps an applicant, resident, participant, or household member request a reasonable accommodation because of a disability. A reasonable accommodation is a change, exception, or adjustment to a rule, policy, practice, procedure, service, or program that may be necessary to provide an equal opportunity to use and enjoy housing or participate in a housing program.

IMPORTANT INFORMATION

- You may request a reasonable accommodation at any time. A request may be made orally or in writing. Use of this form is intended to assist with processing and documentation.
- If the disability and the disability-related need are obvious or already known to WCHA, additional verification should not be requested solely to confirm information already known or apparent.
- When the disability or disability-related need is not obvious or known, WCHA may request reliable information necessary to verify disability status and/or the relationship between the disability and the requested accommodation.
- WCHA does not need detailed medical records or a complete medical history. Verification should be limited to information necessary to evaluate the request.
- If the requested accommodation cannot be granted as submitted, WCHA may discuss effective alternatives through an interactive process.

PACKET CONTENTS

Form 1 Request for Reasonable Accommodation

Form 2 Authorization and Limited Third-Party Verification

Form 3 WCHA Interactive Process Review Worksheet

Form 4 WCHA Written Determination

Form 5 Request for Reconsideration / Additional Information

Form 6 WCHA Case Tracking Checklist

RETURN / ASSISTANCE

Return completed requests to:

Washington County Housing Authority
100 S. Franklin Street
Washington, PA 15301
Attn: HCVP

If you need this packet in an alternative format or need assistance completing it, contact WCHA at 724-228-6060 or TDD 724-228-6083.

WASHINGTON COUNTY HOUSING AUTHORITY

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Monique Taylor
Dipesh Patel
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DENNIS C. FISHER
Interim Deputy Executive Director

GARY J. MATTA
Solicitor

FORM 1 — REQUEST FOR REASONABLE ACCOMMODATION

A. REQUESTER / HOUSEHOLD INFORMATION

Head of Household / Applicant

Person Needing the Accommodation (if different)

Current Address

City / State / ZIP

Phone

Email

Program / Status

☐ Housing Choice Voucher (Section 8) ☐ Applicant / Waiting List Public Housing

WCHA Property / Development or Program, if applicable

B. ACCOMMODATION REQUEST

Describe the specific change, exception, adjustment, service, auxiliary aid, or other accommodation you are requesting.

Accommodation Requested

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FORM 1 — REQUEST FOR REASONABLE ACCOMMODATION — CONTINUED

B. ACCOMMODATION REQUEST · CONTINUED

Explain how the requested accommodation is related to the disability and how it will provide equal access to, use of, or participation in WCHA housing or programs. Do not provide a diagnosis unless you choose to do so.

Disability-Related Need / Connection to Accommodation

Is the disability and disability-related need obvious or already known to WCHA?

☐ Yes ☐ No ☐ Unsure

Is this request urgent because delay may affect health, safety, housing stability, a deadline, or program access?

☐ No ☐ Yes

If Yes, Explain the Time-Sensitive Circumstance

If you are requesting a physical modification, describe the proposed modification and location.

Physical Modification / Location, if applicable

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FORM 1 — REQUEST FOR REASONABLE ACCOMMODATION — CONTINUED

C. COMMUNICATION / REPRESENTATIVE

May WCHA communicate with another person about this request?

☐ No ☐ Yes

Representative / Advocate Name

Relationship

Phone / Email

Preferred Communication Method

☐ Mail ☐ Phone ☐ Email ☐ Other

Other Communication Method, if selected

D. CERTIFICATION AND SIGNATURE

I certify that the information I provided in this request is true and complete to the best of my knowledge. I understand WCHA may request limited, reliable verification when the disability or disability-related need is not obvious or already known.

Requester / Authorized Representative Signature

Date

Printed Name

WCHA STAFF USE

Date Received

Received By

☐ Oral request documented by staff.

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FORM 2 — AUTHORIZATION AND LIMITED THIRD-PARTY VERIFICATION

Complete only when verification is needed to evaluate the request

A. APPLICANT / RESIDENT / PARTICIPANT AUTHORIZATION

Name of Person Needing the Accommodation

Date of Birth (optional, if needed to identify records)

I authorize the professional or other reliable third party identified below to provide WCHA only the information requested on this form concerning whether I have
a disability for fair housing/program access purposes and whether there is a disability-related need for the requested accommodation. This authorization does
not request or authorize release of my complete medical records, detailed medical history, or information unrelated to this accommodation request.

Verifier / Organization

Requester ? Type Full Name as Signature **Date**

This authorization expires 90 days after signature unless revoked earlier in writing, to the extent permitted by law.

B. TO THE KNOWLEDGEABLE PROFESSIONAL / RELIABLE THIRD PARTY

WCHA is evaluating a reasonable accommodation request. Please answer only the questions requested. Do not provide a diagnosis, detailed treatment history,
medications, medical records, or unrelated confidential information.

For this form, disability generally means a physical or mental impairment that substantially limits one or more major life activities, a record of such an
impairment, or being regarded as having such an impairment, as applicable under federal fair housing and disability requirements.

1. Based on your knowledge, does the person meet the applicable definition of a person with a disability?

☐ Yes ☐ No ☐ Unable to determine

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FORM 2 — LIMITED THIRD-PARTY VERIFICATION — CONTINUED

2. Does the person have a disability-related need for the requested accommodation?

☐ Yes ☐ No ☐ Unable to determine

Requested Accommodation

Without stating a diagnosis, briefly describe the connection between the functional limitation caused by the disability and the need for the requested accommodation.

Functional Limitation / Disability-Related Need and Nexus

If the exact accommodation requested is not necessary or is not the only effective option, identify any alternative accommodation that may address the disability-related need.

Effective Alternative, if known

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FORM 2 — LIMITED THIRD-PARTY VERIFICATION — CONTINUED

C. VERIFIER CERTIFICATION

I certify that the information above is based on my professional, service-provider, or other reliable knowledge of the individual and is accurate to the best of my knowledge.

Verifier Name

Title / Professional or Service Relationship

Organization / Agency

Phone / Email / Address

Verifier ? Type Full Name as Signature

Date

WCHA CONFIDENTIALITY NOTICE

Information concerning disability status and reasonable accommodation requests is confidential. WCHA should use and disclose this information only as necessary to evaluate, implement, document, and administer the accommodation request and applicable program requirements.

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FORM 3 — INTERACTIVE PROCESS REVIEW WORKSHEET

CONFIDENTIAL — WCHA INTERNAL USE

Requester

Program / Property

Date Request Received

Assigned Staff

Accommodation Requested

INITIAL REVIEW

- ☐ Request identifies a change, exception, adjustment, aid, service, or other accommodation.
- ☐ Disability is obvious or already known. No additional disability verification is needed.
- ☐ Disability is not obvious or known. Limited verification is needed.
- ☐ Disability-related need is obvious or known. No additional nexus verification is needed.
- ☐ Disability-related need is not obvious or known. Limited nexus verification is needed.
- ☐ Request is time-sensitive. Interim action considered, if appropriate.

INTERACTIVE PROCESS

Dates of Contact / Participants

Information Discussed / Clarification Requested

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FORM 3 — INTERACTIVE PROCESS REVIEW WORKSHEET — CONTINUED

CONFIDENTIAL — WCHA INTERNAL USE

Effective Alternatives Considered

ADMINISTRATIVE / PROGRAM REVIEW

- ☐ Requested accommodation can be granted as submitted.
- ☐ An effective alternative has been identified.
- ☐ Potential undue financial and administrative burden requires documented analysis.
- ☐ Potential fundamental alteration requires documented analysis.
- ☐ Other legal/program issue requires supervisory or counsel review.

Analysis / Supporting Facts ? Avoid Unsupported Conclusions

Recommended Determination and Implementation Steps

Reviewed By / Title

Date

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FORM 4 — WRITTEN DETERMINATION

Date

To

Address / Email

Reasonable Accommodation Request Date

WCHA has reviewed your reasonable accommodation request and any information necessary to evaluate the request.

DETERMINATION

☐ APPROVED · Your request is approved as submitted.

☐ APPROVED WITH AN EFFECTIVE ALTERNATIVE · WCHA has approved the accommodation described below.

☐ ADDITIONAL LIMITED INFORMATION NEEDED · WCHA needs the specific information described below.

☐ DENIED · Based on the individualized review described below, WCHA is denying the request.

Approved Accommodation / Alternative / Information Needed / Basis for Decision

WASHINGTON COUNTY HOUSING AUTHORITY

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FORM 4 — WRITTEN DETERMINATION — CONTINUED

Implementation Date or Next Action

IF THE REQUEST IS DENIED OR NOT GRANTED AS SUBMITTED

WCHA's determination is based on an individualized review of the request and available information. If another effective accommodation may address the disability-related need, WCHA remains available to discuss alternatives. You may contact WCHA to request reconsideration, provide additional relevant information, or use any review, grievance, informal review, or informal hearing rights available under the applicable WCHA policy and housing program.

If you believe you have experienced housing discrimination, you may also contact the U.S. Department of Housing and Urban Development, Office of Fair Housing and Equal Opportunity.

WCHA Staff Name / Title

WCHA Staff ? Type Full Name as Signature

Date

Contact Information / Next Step

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FORM 5 — REQUEST FOR RECONSIDERATION / ADDITIONAL INFORMATION

Use of this form is optional. You may provide additional relevant information or ask WCHA to reconsider a reasonable accommodation determination.

Name

Program / Property

Date of WCHA Determination

WHAT ARE YOU ASKING WCHA TO RECONSIDER?

Reconsideration Request

ADDITIONAL RELEVANT INFORMATION

Explain any additional information about your disability-related need, the requested accommodation, or an effective alternative. Do not submit unrelated medical records.

Additional Relevant Information

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FORM 5 — REQUEST FOR RECONSIDERATION — CONTINUED

☐ I would like WCHA to contact me to discuss an effective alternative.

☐ I am submitting additional documentation with this request.

☐ I need assistance or an auxiliary aid/service to participate in the review process.

Requester ? Type Full Name as Signature **Date**

Preferred Contact Method

100 S. Franklin Street
Washington, Pennsylvania 15301
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FORM 6 — REASONABLE ACCOMMODATION CASE TRACKING CHECKLIST

CONFIDENTIAL — WCHA INTERNAL USE

Requester

Program / Property

Case / Client Number

CASE TRACKING

ACTION	DATE	STAFF / METHOD
Request received / oral request documented		
Acknowledgment / assistance provided		
Initial review completed		
Limited verification requested, if needed		
Verification received		
Interactive process contact		
Supervisor / counsel review, if needed		
Determination issued		
Accommodation implemented		
Follow-up completed		
Reconsideration / review request		

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FORM 6 — QUALITY-CONTROL CHECKLIST

CONFIDENTIAL — WCHA INTERNAL USE

QUALITY-CONTROL REVIEW

- ☐ Only information necessary to evaluate the request was requested.
- ☐ No diagnosis or complete medical record was required unless specifically necessary and legally appropriate.
- ☐ The request received an individualized review.
- ☐ The interactive process and effective alternatives were considered when appropriate.
- ☐ Any undue burden or fundamental alteration analysis is supported by specific facts and appropriate review.
- ☐ Written notice was issued and implementation responsibilities were assigned.
- ☐ Confidential information is stored and disclosed only as necessary.

FINAL REVIEW NOTES

Final Quality-Control / Case Closure Notes

Reviewed By / Title

Date