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

REQUEST TO LEASE FROM A RELATIVE AS A REASONABLE ACCOMMODATION

Housing Choice Voucher Program • 24 CFR 982.306(d)

Federal HCV rules generally prohibit approval of a tenancy when the owner is the parent, child, grandparent, grandchild, sister, or brother of any member of the assisted family. WCHA may make an exception when leasing the unit is needed as a reasonable accommodation for a family member with a disability. Each request is evaluated on a case-by-case basis.

A. FAMILY / PARTICIPANT INFORMATION

Head of Household / Participant Name

Client / Voucher Number (if applicable)

Current Address

Phone

Email

Household Member for Whom the Accommodation Is Requested

B. PROPOSED RELATIVE-OWNED UNIT

Address of Proposed Unit

Proposed Owner / Landlord Name

Owner Phone / Email

Owner's Relationship to a Member of the Assisted Family

- ☐ Parent
- ☐ Child
- ☐ Grandparent
- ☐ Grandchild
- ☐ Sister
- ☐ Brother

Name of Assisted Family Member Related to the Owner

C. ACCOMMODATION REQUEST - DISABILITY-RELATED NEED

Explain why leasing this particular unit from the relative is needed because of the disability. Describe the disability-related functional need and how this unit, its location, accessibility, proximity to support, or another circumstance addresses that need. Do not provide a diagnosis or medical records.

Disability-Related Need and Connection to This Specific Unit

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Monique Taylor
Dipesh Patel
Clyde Wilhelm

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Interim Deputy Executive Director

GARY J. MATTA
Solicitor

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C. ACCOMMODATION REQUEST - CONTINUED

Identify the specific feature, location, support arrangement, accessibility characteristic, proximity, or other circumstance of the proposed unit that is important to the disability-related need.

Specific Unit / Location / Support Features

D. OTHER HOUSING / EFFECTIVE ALTERNATIVES

These questions help WCHA evaluate the disability-related need and whether an effective alternative is available. A relative's willingness to rent, lower rent, convenience, or the family relationship alone does not establish a disability-related need.

Describe housing considered or searched for and why it does not effectively meet the identified disability-related need.

Could another accommodation or another unit effectively meet the same disability-related need? Explain.

E. REQUESTER CERTIFICATION

I request that WCHA approve the proposed tenancy as an exception to the leasing-to-relatives restriction because the tenancy is needed as a reasonable accommodation for a family member with a disability. I certify that the information provided is true and complete to the best of my knowledge. I understand WCHA may request only information necessary to evaluate the disability-related need and may discuss effective alternatives with me.

Requester / Authorized Representative - Type Full Name as Signature

Date

If Signed by Representative, Relationship / Authority

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WCHA INITIAL REVIEW - STAFF USE ONLY

F. WCHA STAFF USE ONLY - CONFIDENTIAL

☐ Request was initially made orally and documented by WCHA staff.

Date Received

Received By

Initial Verification Review

☐ Disability is obvious or already known to WCHA.

☐ Disability-related need / nexus is obvious or already known.

☐ Limited third-party verification is needed.

☐ No additional verification is needed.

Initial Review Notes / Deadline / Interim Action Considered

ADMINISTRATIVE PLAN RESPONSE TIME

After a request for an accommodation is presented, WCHA will respond in writing within 10 business days. Before making a determination, WCHA may discuss and negotiate with the family, request additional information, or require consent so WCHA may verify the need for the requested accommodation.

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THIRD-PARTY VERIFICATION OF DISABILITY-RELATED NEED

Lease From a Relative Reasonable Accommodation Request

IMPORTANT: WCHA requests only information necessary to evaluate the disability-related need for the requested accommodation. Do not provide medical records, a diagnosis, treatment information, medications, or details concerning the nature or extent of the disability.

A. REQUESTER AUTHORIZATION

Name of Person With a Disability

Requested Accommodation / Proposed Relative-Owned Unit

Owner Name and Relationship to Assisted Family

I authorize the knowledgeable professional or reliable third party identified below to provide WCHA only the limited information requested regarding disability status, if needed, and the disability-related need for approval to lease the proposed relative-owned unit. This does not authorize release of medical records.

Requester - Type Full Name as Signature

Date

B. TO THE KNOWLEDGEABLE PROFESSIONAL / RELIABLE THIRD PARTY

WCHA's Administrative Plan permits verification from an individual identified by the family who is competent to make the determination. This may include a doctor or other medical professional, peer support group, non-medical service agency, or reliable third party in a position to know about the individual's disability.

1. Is the individual a person with a disability for federal housing civil rights purposes?

☐ Yes ☐ No ☐ Unable to determine

2. Is there a disability-related need to lease the specific proposed relative-owned unit?

☐ Yes ☐ No ☐ Unable to determine

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THIRD-PARTY VERIFICATION OF DISABILITY-RELATED NEED - CONTINUED

C. LIMITED VERIFICATION OF NEXUS

Without identifying a diagnosis or describing the nature or extent of the disability, explain the connection (nexus) between the individual's disability-related functional limitation or need and leasing this specific unit from the relative.

Disability-Related Need / Nexus

D. SPECIFIC NEED FOR THE PROPOSED UNIT

Identify the disability-related feature, location, support, accessibility characteristic, proximity, or other circumstance that makes the proposed unit effective in meeting the individual's disability-related need.

Specific Need Addressed by the Proposed Unit

Would another unit or another accommodation effectively meet the same disability-related need?

☐ Yes ☐ No ☐ Unable to determine

If yes, describe an effective alternative. If no, briefly explain why the proposed unit is specifically needed.

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THIRD-PARTY VERIFICATION - CERTIFICATION AND WCHA REVIEW

E. VERIFIER CERTIFICATION

I certify that the information provided is based on my professional, service-provider, or other reliable knowledge of the individual and is accurate to the best of my knowledge. I understand WCHA does not request medical records or information concerning the nature or extent of the disability.

Verifier Name

Title / Professional or Service Relationship

Organization / Agency

Phone / Email / Address

Verifier - Type Full Name as Signature

Date

F. WCHA CONFIDENTIAL REVIEW - STAFF USE ONLY

☐ Disability verified / already known.

☐ Disability-related need / nexus verified.

☐ Additional limited information is needed.

☐ Interactive process / alternatives discussion is needed.

Case-by-Case Analysis / Notes

WCHA ADMINISTRATIVE PLAN APPROVAL CRITERIA

The PHA must approve a request when: (1) the request was made by or on behalf of a person with a disability; (2) there is a disability-related need for the accommodation; and (3) the requested accommodation is reasonable, meaning it would not impose an undue financial and administrative burden on the PHA or fundamentally alter the nature of the PHA's HCV operations.