Tennessee Housing Development Agency

Housing Choice Voucher Program
Reasonable Accommodation Request Form

Part I: Head of Household Information

Date:

Head of Household:

Current Address:

THDA Specialist:

Initial Request:

Recertification:

Part II: Person with a Disability in Need of an Accommodation

Name of Person with a Disability:

Relation to Head of Household:

Note: Part I and II are completed by THDA. **The named person with a disability or their legal representative must complete Part III.**

Part III: Accommodation Request - Please complete Sections 1 and 2.

Section 1.

As a result of a disability, I am requesting the following reasonable accommodation on behalf of myself, or as a legal representative to the individual listed above, so that I, or he, or she may successfully use and enjoy a dwelling unit subsidized through the Housing Choice Voucher (HCV) Program. **[Select and complete all parts that apply in Section 1: Part A, B, C, D.]**

☐ **Part A. A Voucher Term Extension Beyond 120 Days**

I acknowledge that to qualify for additional search time, I must request the extension before the voucher expires and verify that an issue related to the disabling conditions prevented the head of household from searching for or locating suitable housing in the initial 4 months offered. Please describe the issue that caused the delay in your housing search:

☐ **Part B. An Additional Bedroom For Something Other Than A Live-In Aide**

If you are only seeking a Live-In Aide, please do not fill out this part and instead complete Part C for a Live-In Aide. If you need a Live-In Aide and an additional bedroom for a separate reason, please fill out Part B and Part C. Please explain the need for an additional bedroom and how that need is related specifically to the disabling conditions:

If you are requesting a larger subsidy size due to the need to store medicine, medical equipment or a medical apparatus, please list **all** the necessary medicine (with quantity), equipment, or apparatus to be stored in the unit:

☐ **Part C. A Live In Aide to Assist the Person with a Disability**

[Items 1-12 must be fully completed to process your request for a live-in aide.]

(1) Full Name of the Proposed Live-In Aide:

(2) Their Current Address:

(3) Is the proposed Live-In Aide related to anyone in the household? ☐ Yes ☐ No

Relationship (mother, brother, etc.):

(4) What is their gender? ☐ Male ☐ Female

(5) What is their birth date?

(6) Are they a U.S. Citizen? ☐ Yes ☐ No

(7) Are they disabled? ☐ Yes ☐ No

(8) Is the care of the person with a disability the sole or only reason the Live-In Aide will live in the home? ☐ Yes ☐ No

If No, for what other reason(s) will the Live-In Aide be moving into the assisted unit?

(9) Explain how a Live-In Aide is essential to the care/well-being of the person with a disability:

(10) Is the Live-In Aide needed Full-Time or Part-Time? ☐ Full-time ☐ Part-time
If part-time, list the hours needed (i.e. 9 am to 3 pm):

(11) How much will the Live-In Aide be paid (include rate and frequency (hourly, daily, etc.):

(12) Is/Will the proposed Live-In Aide be employed outside of the home? ☐ Yes ☐ No
If YES: ☐ Full time ☐ Part time # of hours per week:
☐ Day time ☐ Evening ☐ Varies

☐ **Part D. Reasonable Accommodation Needed is not Listed Above.**

If the Reasonable Accommodation you are seeking is not listed above, please clearly describe your request for accommodation and explain what rule, policy, or procedure you want THDA to consider changing. (Example: Requesting a ground floor unit, breaking a first year's lease, a change in the way THDA communicates with you, etc.).

Section 2.

Please explain why the request for Reasonable Accommodation is necessary:

You must complete **Part IV: Authorization and Release** for THDA to certify the above information.

Part IV: Authorization & Release

[To be completed by the individual with the disability or their legal representative]

I, the person with a disability or their legal representative, do hereby certify that the information contained herein is true and complete, and I authorize and release Tennessee Housing Development Agency (THDA) to certify that the claimed disabling conditions substantially limit (to a large degree) a major life activity such as seeing, hearing, walking, breathing, performing manual tasks, caring for one's self, learning, and speaking, as defined by the Fair Housing Act (Title VIII of the Civil Rights Act of 1968 at 42 U.S.C. 3601-3619), and the accommodation requested is necessary to successfully use and enjoy the assisted unit. I understand there must be an identifiable relationship between the requested accommodation and the disability.

To certify this information, I authorize THDA to contact the following physician or health care professional (licensed psychologist, licensed nurse practitioner, rehabilitation professional, non-medical service agency whose function is to provide services to the disabled, or other licensed health professional) who is familiar with the requesting person's disability and its relationship to the requested accommodation.

I understand that the information obtained by THDA will be kept completely confidential and used solely to decide on my reasonable accommodation request.

All Information requested below must be provided and legible or the form will be returned.

Name of Physician or Health Care Provider:

Title: Address (include city, state, zip):

Phone:

Email or fax number: Name of Medical Facility:

Signature of the Person with a Disability or their Legal Representative:

SIGNATURE DATE

CURRENT TELEPHONE NUMBER:

If anyone other than the named person with a disability is signing, except for a guardian signing for a minor, the legal representative MUST provide THDA with the documentation that gives them the legal right to sign on behalf of the named person with a disability.

Note: Title 18, Section 1̲1 of the United States Code, states that a person who knowingly and willingly makes false or fraudulent statements to any department or agency of the United States or the Department of Housing and Urban Development is guilty of a felony.

PLEASE RETURN THIS FORM TO:

THDA HCV Program – RA Requests
502 Deaderick Street, Third Floor
Nashville, Tennessee 37243

Email: RARequest@thda.org
Fax (615) 916-5051
Telephone: 615-815-2165