Prince William County
Office of Housing and
Community Development
15941 Donald Curtis Drive, Suite 112
Woodbridge, VA 22191
PHONE: 703-792-7530
FAX: 703-792-4978
www.pwcgov.org/housing

FAMILY REQUEST FOR REASONABLE ACCOMMODATION

(THIS FORM IS AVAILABLE IN LARGER FONT OR ALTERNATIVE FORMAT UPON REQUEST)

PLEASE PRINT CLEARLY

Head of Household: _____ **TDD/Phone:** _____

Address: _____ **State/Zip:** _____

Currently, I am:

- ☐ **An applicant on the waiting list for the Housing Choice Voucher (Section 8) program**
- ☐ **A participant in the Housing Choice Voucher (Section 8) program**

Household member who needs accommodation: _____

The household member above has a disability because he or she has a physical, mental or emotional impairment that limits one or more life activities or has a record of having such an impairment.

Please fill out all the following information regarding the person who needs the accommodation(s). It is important for you to provide this detail in order for the Prince William County Office of Housing and Community Development (OHCD) to best evaluate this request. *Please DO NOT submit medical records or provide confidential medical information regarding the nature or extent of the disability.*

As a result of this disability, I am requesting the following reasonable accommodation(s) from OHCD for the disabled household member listed above. Please answer the questions below.

☐ The household member **needs a live-in aide** in order to afford the household member equal use and enjoyment of the dwelling unit.

A daily in-home worker, housekeeper, or rotating shifts are not equally effective as a reasonable accommodation because (please indicate in box):

☐ Extra bedroom for medical equipment. Indicate the floor space in square footage of the medical equipment: _____

All living and sleeping rooms in the current unit are not sufficient to meet the disability-related need because (please indicate):

☐ The household member needs a change in a rule, policy or procedure. (Note that fundamental requirements must still be met). Please specify the necessary change. Attach additional pages if necessary.

☐ Other (for example, a change in the way the housing authority communicates with you). Please specify the necessary change. Provide additional pages if necessary.

I understand that the information obtained by the housing authority will be kept completely confidential and used solely to make a determination on my reasonable accommodation request.

FRAUD AND FALSE STATEMENTS

Title 18, Section 1001 of the U.S. Code states that a person who knowingly and willingly makes false and fraudulent statements to any department of the United States Government, including the Department of Housing and Urban Development (HUD), a public housing authority (PHA), and any owner (or employee of HUD, the PHA, or the owner) may be subject to penalties that include fines and/or imprisonment.

I certify by signing below that all the information provided above is true, accurate and complete to the best of my knowledge.

Signature _____ Date _____

For PHA Use ONLY: PHA Certification

☐ I certify that this individual's disability is obvious or otherwise known to the PHA and no further verification is required.

☐ I certify that this individual's need for the accommodation is readily apparent or known to the PHA and no further verification is required.

Signature of Housing Program Specialist _____ Date _____

Approval of Housing Program Specialist Supervisor _____ Date _____

EQUAL HOUSING OPPORTUNITY

AUTHORIZATION

I/we authorize the Housing Authority (PHA) to verify that the above-referenced household member has a disability and that the accommodation(s) requested is necessary in order to remove or alleviate barriers to housing. To verify this information, the housing authority may contact the below-named professional who is knowledgeable about my situation and competent to render a professional opinion. I understand the information the housing authority obtains will be kept completely confidential and used solely to evaluate the request.

This authorization is requested because third-party verification may be needed.

Name of Professional: _____

Field of Practice: _____ Agency/Clinic/Facility: _____

License #, if applicable: _____ Email: _____

Address: _____

Phone: (___) _____ FAX: _____

X _____ _____

Signature of Head of Household or authorized Guardian ** Date

**** If the family member needing the accommodation(s) is under 18 years of age, are you the parent or guardian of the household member? ☐ Yes ☐ No**

X _____ _____

Signature of family member needing the accommodation
(only if 18 years of age or older) Date

Please return this form as promptly as possible so that the housing authority may make a determination on this request.

_____ _____

PHA Representative Date

_____ _____

Phone Email