



VICKI BEEN  
Commissioner  
LAURIE LoPRIMO  
Assistant Commissioner

Office of Financial Management  
and Analysis  
Division of Tenant Resources  
100 Gold Street  
New York, N.Y. 10038

**REQUEST FOR REASONABLE ACCOMMODATION**

Date: \_\_\_\_\_

Head of Household: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

This form should be completed to request an exception to policy or procedure so that a disabled member of a household will have the opportunity to participate in and benefit from the HPD Section 8 Program. HPD will contact the health care professional indicated by the family below who should be able to attest that the household member is requesting an accommodation is disabled and in need of the reasonable accommodation requested. HPD must receive a completed Verification of Reasonable Accommodation by your health care professional within 15 calendar days. HPD will not take action on any Reasonable Accommodation requests until a completed Verification of Reasonable Accommodation has been returned to HPD.

Name of the household member on whose behalf reasonable accommodation is requested \_\_\_\_\_

Relationship to Head of Household: \_\_\_\_\_

What type of reasonable accommodation are you requesting? (Examples: extension of voucher time, exception to subsidy standards, exception to leasing from a relative)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name of Health Care Provider: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

I certify that the above statements are true to the best of my knowledge. I understand that supplying false statements and information can lead to a denial of my reasonable accommodation request and jeopardize my housing subsidy. I authorize the New York City Department of Housing Preservation and Development to verify my eligibility for the accommodation requested.

Household member requesting accommodation:

Printed Name

Signature (if under 18, parent or legal guardian)

Date



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**REASONABLE ACCOMMODATION VERIFICATION FORM**

Head of Household: \_\_\_\_\_

Name of person requesting Reasonable Accommodation: \_\_\_\_\_

To Whom It May Concern:

The New York City Department of Housing Preservation and Development (HPD) Section 8 program provide reasonable accommodations to a family who is either applying for or receiving housing subsidy assistance to allow equal access to the program. The above named person(s) has listed you as a health care professional to provide verification for a reasonable accommodation request. You may include additional relevant information, but please refrain from discussing a person’s diagnosis or any other information that is not directly relevant to the request for a reasonable accommodation.

Please complete the *Reasonable Accommodation Verification* form and return within 15 calendar days directly to:

New York City Department of Housing Preservation and Development  
Division of Tenant Resources  
Continued Occupancy Unit  
100 Gold Street Rm. 1-M9  
New York, NY 10038  
ATTN: Continued Occupancy Project Manager

If you have any questions on how to complete this form, please call (917) 286-4300. Thank you in advance for your cooperation.

Sincerely,

Section 8 Case Manager

**WARNING: Providing false statements to a government agency is punishable under federal law and may result in the household’s loss of subsidy.**

**REASONABLE ACCOMMODATION VERIFICATION FORM**

Head of Household: \_\_\_\_\_

Address: \_\_\_\_\_

Name of the household member on whose behalf reasonable accommodation is requested \_\_\_\_\_

Relationship to Head of Household: \_\_\_\_\_

Accommodation Requested:  
\_\_\_\_\_  
\_\_\_\_\_

**SECTION A: CERTIFICATION OF DISABILITY**

For the purpose of reasonable accommodation, a person has a disability if they:

1. have a physical or mental impairment that substantially limits one or more major life activities
2. have a Record of such an impairment
3. are regarded as having such an impairment

Does the above named individual meet the definition of disabled?  Yes  No

If yes, which major life activities are affected?  
\_\_\_\_\_  
\_\_\_\_\_

**SECTION B: CONNECTION BETWEEN DISABILITY AND REQUESTED ACCOMMODATION**

Is there a connection between the accommodation requested above and the person's disability?

Yes  No

If yes, how is the accommodation linked to the person's disability?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SECTION C: CERTIFICATION**

I certify the information above is accurate and true to the best of my knowledge.

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

License Number: \_\_\_\_\_ Agency Name: \_\_\_\_\_