NYC
Department of Housing Preservation & Development
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MARIA TORRES-SPRINGER
Commissioner
DON SHACKNAI
First Deputy Commissioner
EVA TRIMBLE
Deputy Commissioner
LAURIE LoPRIMO
Assistant Commissioner

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

# REASONABLE ACCOMMODATION REQUEST

**To the Participant or Applicant:** Complete this page to request an exception to an HPD rental assistance policy or procedure, such as a larger voucher size or moving in the first year of your lease. HPD may approve the request if a connection is made between the disability of the household member and the reasonable accommodation request. For the purpose of reasonable accommodation, a person has a disability if they: *have a physical or mental impairment that substantially limits one or more major life activities; have a record of such impairment, or are considered as having such impairment.* Below, name the health care provider responsible for services related to your disability and have that person complete the *Reasonable Accommodation Verification* on the next page. **Return the completed forms by mail, fax, or email to the contact below**. If you have questions, please call Client Services: 917-286-4300.

## PARTICIPANT / APPLICANT: HOUSEHOLD INFORMATION

Head of Household: ____________________ Phone Number: ____________________ Date: ____________

Street Address: ________________________________ Email: ____________________

Name of person requesting reasonable accommodation: ________________________________

## PARTICIPANT / APPLICANT: ACCOMMODATION REQUEST

*Describe specifically what is needed to accommodate your disability:* ________________________________

*Describe why this accommodation is needed for your disability:* ________________________________

Name of Health Care Provider: ____________________ Phone Number: ____________________

Address: ____________________ Fax: ____________________

**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 NYC Department of Housing Preservation and Development to verify my eligibility for the accommodation requested. To verify this information, I authorize HPD to contact the health care provider listed above and allow the provider to release information to HPD.**

________________________________

Requestor's Signature (if under 18, parent or legal guardian) Date

**Please return completed forms to:**
NYC Department of Housing Preservation and Development
Division of Tenant Resources
100 Gold St., Rm. 4Z2C, New York, NY 10038
Attn: Executive Assistant

**FAX:** 212-863-5299
**EMAIL:** DTRAI@hpd.nyc.gov

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# REASONABLE ACCOMMODATION VERIFICATION

***To be completed by a medical professional***

**To the Health Care Provider:** The NYC Department of Housing Preservation and Development (HPD) provides reasonable accommodation to a household who is either applying for, or receiving, rental assistance in order to allow equal access to the program. HPD may grant an exception to an HPD rental assistance policy or procedure if a connection is made between the disability of the household member and the reasonable accommodation request. The person completing this request has listed you as a health care professional that can verify the need for reasonable accommodation. Please only include medical information below that is directly relevant to the request for a reasonable accommodation.

## PARTICIPANT / APPLICANT: REQUEST INFORMATION

Head of Household: ____________________ Person Requesting Accommodation: ____________________

Requested Accommodation: ________________________________________

## HEALTH CARE PROVIDER: VERIFICATION OF DISABILITY

For the purpose of reasonable accommodation, a person has a disability if they: *have a physical or mental impairment that substantially limits one or more major life activities; have a record of such impairment, or are regarded as having such impairment.*

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

If **yes**, which major life activities are affected? ________________________________________

________________________________________

________________________________________

________________________________________

## HEALTH CARE PROVIDER: CONNECTION BETWEEN DISABILITY AND REQUESTED ACCOMMODATION

Is there a connection between the requested accommodation and the person's disability? ☐ Yes ☐ No

If **yes**, how is the accommodation linked to the person's disability? *(Note: in order for an accommodation to be considered, a connection must be made between the disability and the requested accommodation.)* ____________________

________________________________________

________________________________________

________________________________________

## HEALTH CARE PROVIDER: CERTIFICATION

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

Name: ____________________ Title: ____________________

Signature: ____________________ Date: ____________ Phone Number: ____________

License Number: ____________________ Agency Name: ____________________

***Health Care Provider: Place medical stamp below.***

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