Wallingford Housing Authority
45 Tremper Dr.
Wallingford, CT 06492

RA Form #1- CERTIFICATION OF NEED FOR REASONABLE ACCOMMODATION

This questionnaire is to be administered to every applicant of the Wallingford Housing Authority (WHA). It is used to determine whether an applicant's family or resident needs special features within their work area or housing unit. The need for special adaptations must be verified in order to assure the needs are met and a limited number of units with special features go to families that actually need the features.

Please be sure to answer all applicable questions on this form.

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

Household Member who needs an accommodation: _____

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

Currently I am:

- ❒ An applicant on the waiting list for:
  - ❒ The Housing Choice Voucher (Section 8) program
  - ❒ Other Housing Authority- owned unit
- ❒ Currently a participant in the Housing Choice Voucher (Section 8) Program
- ❒ Currently living in Public Housing or other Housing Authority- owned property

I am requesting the following reasonable accommodation: (Please check one or more boxes below)

- ❒ A barrier- free apartment ❒ One-level unit
- ❒ Extra Bedroom ❒ Accommodation for a Live-In Attendant
- ❒ Unit for vision-impaired ❒ Unit for hearing-impaired
- ❒ Mobility Counseling ❒ 1st Fl Bedroom & Bath (Family)
- ❒ Other: _____

Can you and all family members use the stairs unassisted? ❒ **Yes** ❒ **No**
If no, please indicate how WHA should accommodate your family:

_____

_____

If you checked any of the above listed categories of units, please explain exactly what you need to accommodate your situation. *Attach additional pages as necessary.*_____

Applicant/Resident Certification

I, _____ authorize the Wallingford Housing Authority to verify that I have a disability and have the need for the reasonable accommodation I have requested. In order to verify this information WHA will need to contact any of the following providers: psychiatrist, licensed nurse practitioner, licensed social worker, rehabilitation professional, non- medical service agency whose function is to provide services to the disabled; or any other expert in the field of _____.

Name of expert: _____

Title of professional expert: _____

Agency, Facility or institution: _____

Phone: _____ Fax: _____

Address: _____

I understand that the information obtained by WHA will be kept confidential and used solely to make a determination on my reasonable accommodation request. Please return this form as promptly as possible so that WHA may make a determination on your request.

Print Name: _____ Date: _____

Signature: _____ Date: _____

Where the individual with the disability is over 18 and is not the head of household, he/she must also sign the authorization verification.

Signature of person over 18 with disability: _____ Date: _____