1235 34th St.
Missoula, MT 59801
(406)549-4113

Request For a Reasonable Accommodation

If you, a member of your household, or someone associated with you has a disability, and feel that there is a need for a reasonable accommodation for that person to have equal use and access to the community, please complete this form and give the form to your housing provider. Check all items that apply and explain fully. If you cannot fill out this form yourself, you may have someone assist you. Please keep copies of all documents that you submit to your housing provider.

Name of Tenant or Applicant: _____

Date: _____

Name of person with disability: _____

Phone Number: _____

Address: _____

_____

I am requesting the following change or changes in a policy, procedure, rule, service or regulation so that my household members, guests, and I can live here as easily as others and enjoy and participate equally in housing:

_____

_____

_____

I need this reasonable accommodation because:

_____

_____

_____

MISSOULA HOUSING AUTHORITY

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Request For a Reasonable Accommodation

If you are working with a company, organization, or individual that might be able to help or advise your housing provider on the accommodation request, please provide the following information:

Name: _____

Address: _____

Phone Number: _____

Please notify me within ten working days on the attached Approval or Denial of a Request for a Reasonable Accommodation and/or Reasonable Modification form.

Signature of Tenant, Applicant, or Guest: _____

Date: _____

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Verification of Status as a Person with a Disability

Housing Provider: _____

_____

_____

RE: Name of Tenant/Applicant/Guest Requesting Accommodation and/or Modification:

_____

The tenant, guest, or applicant listed above has sought the reasonable accommodation and/or modification described in the attached Request for a Reasonable Accommodation and/or Modification form. State and federal laws require housing providers to make reasonable modifications and/or accommodations to either the dwelling or other parts of the housing community and/or to policies, procedures, services or regulations when such changes are not unduly burdensome and are necessary because of a disability of an applicant, a household member, or a guest, so that the applicant, household member or guest can have an equal opportunity to use and enjoy the housing and/or facilities.

Federal regulations under the Fair Housing Amendments Act, Section 504 of the Rehabilitation Act of 1973, and the Americans with Disabilities Act, define "disability" as:

- a physical or mental impairment that substantially limits one or more major life activities;
- a record of having such an impairment;
- being regarded as having such an impairment.

A physical or mental impairment includes:

- any physiological disorder or condition;
- cosmetic disfigurement;
- anatomical loss affecting one or more of the following body systems: neurological, musculoskeletal, special sense organs, respiratory, speech organs, cardiovascular, reproductive, digestive, genito-urinary, hemic and lymphatic, skin, and endochrine.
- any mental or psychological disorder, such as cognitive delays, organic brain syndrome, emotional or mental illness, and/or learning disabilities.
- Drug addiction and alcoholism are covered by these provisions as are, for example, cancer, heart disease, HIV, AIDS, and some temporary disabilities (such as broken limbs or symptoms arising from pregnancy).

IMPORTANT: The medical/social service professional certifying the disability and need for an accommodation and/or modification **IS NOT** required to reveal the specific nature and/or severity of the individual's disability, NOR specific information about treatment.

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Verification of Status as a Person with a Disability

As a medical/social service professional with the knowledge necessary to make a determination, I am able to advise that:

_____
(name of client)

Qualifies as an individual with a disability as defined above and that the following accommodation and/or modification is consistent with the needs associated with his/her disability.

Accommodation/Modification Requested:

_____

_____

Expected duration of disability: **LIFETIME**
Specify Length if Not Lifetime: _____

List major life activities that are limited by the disability:

_____

_____

How the accommodation/modification, if approved, will offset the limitations of the major life activities referenced above:

_____

_____

_____

_____
Signature of Medical Professional

_____
Printed Name and Title

Phone Number: _____
Date: _____