Housing & Community Development Division · 200 Georgia Street · Vallejo · CA · 94590 · 707.648.4507

# REASONABLE ACCOMMODATION REQUEST INSTRUCTIONS/INFORMATION

It is the Vallejo Housing Authority's (VHA) policy to provide equal access to all its programs and services. If you are a person with a disability and need a reasonable accommodation in order to fully access and use the VHA's programs and services, please follow the instructions below. If you need assistance with this form, please inform a VHA staff member.

Please be aware that the reasonable accommodation process can take up to 30 days or longer.

**Step 1**
The Head of Household must complete and sign the Request for Reasonable Accommodation form and return it to the VHA. If you do not submit the form to the VHA, the VHA will not be able to process your request.

**Step 2**
Once the VHA receives your completed form, a request will be sent to the health care professional you have told us can verify the need for the accommodation. This person will be asked to verify the following: 1) that the person indicated on the form has a verifiable disability; 2) that there is a "nexus", or a connection, between the disability and the request being made; and 3) that the accommodation is necessary. The health care professional will be asked to return the completed form to the VHA within 15 business days.

**Step 3**
If the health care professional returns the completed form to the VHA within 15 business days, the VHA will review the information provided and determine if you, or your family member, are eligible for the requested accommodation. You will receive written notification from the VHA either giving approval or denying the accommodation request**.**

**If the VHA Denies Your Request…**
The VHA will deny your request if it does not meet the minimum requirements. You may request a review of the decision.

**If Your Health Care Professional Does Not Return the Completed Form to the VHA…**
If the health care professional you indicated on the form does not return the form within 15 business days, the VHA will deny the request due to lack of verification. You will be notified in writing.

If the form is returned but the information is not sufficient to make a determination, additional information will be requested.

NOTE: Reasonable accommodations are valid for a two-year period. If the need for the accommodation still exists after the approved time period ends, you must submit a new request in order to continue receiving the accommodation. You should submit a new request no later than 60 days prior to the date the accommodation was granted to prevent an interruption in receiving the benefit.

**NOTICE TO APPLICANTS/PARTICIPANTS WITH DISABILITIES REGARDING REASONABLE ACCOMMODATION**

The Vallejo Housing Authority (VHA) provides "Reasonable Accommodation" to applicants and/or participants with disabilities in order to ensure equal access to its programs and services. A "Reasonable Accommodation" is a change, exception, or adjustment to a rule, policy, practice or service that may be necessary for a person with a disability to have **equal access** to the VHA's programs and services. The request for the accommodation must be reasonable and not an administrative or financial burden or alter the fundamental nature of the Section 8 program.

If you, or anybody in your household, has a verifiable disability and you need a reasonable accommodation, you can ask for it in writing at any time during the application process or after you get a voucher. All requests are reviewed on a case-by-case basis and the VHA considers all information provided. The accommodation must be for a person with a disability. To be considered disabled, a person must have a disability as described below:

(1) a physical or mental problem that limits one or more major life activities,

(2) having a record of such a problem, or

(3) being regarded as having such a problem

The information the VHA needs to determine if you are eligible for an accommodation includes:

- The type of accommodation needed
- Verification that the accommodation is needed by having an identifiable relationship, or connection, between the requested accommodation and the person's disability
- Information to show how the requested accommodation will accommodate the disability
- Name of the healthcare professional who will verify the disability and the need for the reasonable accommodation

A written response will be mailed to you within approximately 15 business days from the date the VHA receives the information from the healthcare professional. The response will be to approve or deny the request, or to ask for more information needed to complete the review of the request. If the decision is to deny the request, the response will include an explanation of the reasons(s) for the denial.

If the original request is denied, the written response may offer a different accommodation which will still meet your needs, but which does not impose an undue administrative or financial burden or fundamental change to the program.

**VALLEJO HOUSING AUTHORITY**
**200 Georgia St. Vallejo, CA 94590-5905**
**Phone 707 648-4507 FAX 707 648-5249**

# Request for Reasonable Accommodation

Head of Household Name: _____

The Federal Fair Housing Act defines a person with a disability to include (1) individuals with a physical or mental impairment that substantially limits one or more major life activities; (2) individuals who are regarded as having such impairment; and (3) individuals with a record of such impairment.

1. The following household member has a disability as described above:

   Name: _____

   Relationship to head of household: _____

2. The accommodation being requested is: (Please explain the accommodation needed below)

_____

_____

3. What is the connection between the disability and the accommodation being requested? (Please be specific)

_____

_____

**Authorized Release of Information:**
I hereby authorize the healthcare professional named below to release the requested information to the Vallejo Housing Authority (VHA) to verify that I have a disability and have the need for the reasonable accommodation requested above. I understand the information the VHA obtains will be kept confidential and used solely to make a determination on my reasonable accommodation request. I also hereby authorize the VHA to release to said healthcare professional my completed ***Request for Reasonable Accommodation form*** and to verify the contents of both forms with him/her.

**WARNING:** Any person who signs this statement and who willfully states as true any material matter that he/she knows to be false is subject to the penalties prescribed for perjury in **Section 118 of the State Penal Code** and **Section 11054 of the Welfare and Institutions Code**.

Head of Household Signature _____ Date _____

Other Adult Signature (**if applicable**)_____ Date _____

Name of healthcare professional who can verify disability:_____

Title:_____

Address:_____

Phone:_____

Fax:_____

# FOR KAISER PERMANENTE PATIENTS ONLY

KAISER PERMANENTE®

(*Kaiser Permanente entities are listed on reverse side of this form)

## AUTHORIZATION FOR USE OR DISCLOSURE OF PATIENT HEALTH INFORMATION

Note: Fees may apply to certain requests

**Patient Name:** _____

Medical Record number: _____ Birth Date: _____

Address: _____

City: _____ State: _____

Zip Code: _____ Phone #: ( ) _____

Email: _____

**Kaiser Permanente may disclose this information to:** ❑ Check if same as above

**Recipient Name:** _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone # ( ) _____ Email: _____

**This disclosure can be used for the following purpose(s):** ❑ Personal Use ❑ Legal ❑ Insurance ❑ Medical Treatment ❑ Medical Condition Verification ❑ Disability ❑ FMLA ❑ Worker's Comp

**Check one of the following three options to identify the health information to be released.**

❑ **Option 1:** Form Completion (a substitute form or relevant medical records may be released)

❑ **Option 2:** Last 2 years of Kaiser Permanente Medical Office and Kaiser Foundation Hospital records

❑ **Option 3:** ❑ KP Medical Office ❑ Kaiser Foundation Hospital ❑ Immunization ❑ Lab Results ❑ Diagnostic Images ❑ Pharmacy ❑ Copays & Deductibles ❑ Itemized Billing

Complete as applicable
- ❑ For the specific date(s): _____
- ❑ For the specific provider(s): _____
- ❑ For the specific department(s): _____
- ❑ Other: _____

**NOTE:** Hospital and Medical Office records released as part of this authorization may contain references related to mental health, addiction, and HIV medical conditions.

**Check the boxes below if you want this release to include the following information, Otherwise, this information will be excluded.**

❑ Mental Health Treatment Records ❑ Addiction Medicine Treatment Records ❑ HIV Test Results

**Media Type:** ❑ Electronic ❑ Paper **Delivery Preference:** ❑ Electronic ❑ Mail ❑ Pickup

**DURATION:** Authorization shall remain in effect for one year from the date of signature below. However, in Washington, D.C. permission to release addiction medicine treatment records expires after six (6) months.

**REVOCATION:** You or your personal representative may cancel this authorization for future releases by submitting a written request to the Release of Information Unit listed for your region of service on the reverse side of this form. Your cancellation will not affect information that was released prior to receipt of the written request.

**REDISCLOSURE:** Once this information is released, it may not be protected under federal privacy law (HIPAA). State or other federal law may require the recipient to obtain your authorization before further disclosure.

Kaiser Permanente may not condition treatment, payment, enrollment, or eligibility for benefits on whether you sign this authorization. This disclosure is made at your request. For Virginia patients, a copy of this authorization, and a note stating to whom your information was disclosed will be included in your medical record. A copy of the original authorization is valid. You have a right to a copy of this completed authorization.

Date _____ Signature _____ If personal representative, print name/relationship _____

NS-9934 (7-15) SPANISH-NS-1614; CHINESE-NS-6274
NCAL 90258 (REV. 7-15) SPANISH 01782-000; CHINESE 01782-002

ORIGINAL - DISCLOSING PARTY CANARY - PATIENT