

Below is a suggested process and forms for pet and animal control in resident owned communities. Have approved by your board and Lawyer before using.

NOTICE OF RIGHT TO REASONABLE ACCOMMODATION

If you have a disability and you need . . .

- A change in the rules or policies or how we do things that would make it easier for you to live here and use the facilities or take part in programs on site.
- A change or repair in your home that would make it easier for you to live here and use the facilities or take part in programs on site.
- A change or repair to some other part of the housing site that would make it easier for you to live here and use the facilities or take part in programs on site.
- A change in the way we communicate with you or give you information, you can ask for this kind of change, which is called a REASONABLE ACCOMMODATION.

If you can show that you have a disability and your request is reasonable, we will try to make the changes you request or will allow you to make the changes.

We will give you an answer within 14 days of your request, unless there is a problem getting the information we need, or unless you agree to a longer time. We will let you know if we need more information or verification from you or if we would like to talk to you about other ways to meet your needs.

If we turn down your request, we will explain the reasons and you can give us more information if you think that will help. If you need help in filling out a Reasonable Accommodation Request Form, or if you want to give us your request in some other way, we will help you.

The Reasonable Accommodation Request and Verification Forms are attached. Please complete and return all forms so that we may process your request.

(NOTE: In completing the attached forms we are not asking for nor are you required to disclose your disability or any of your medical records or information.)

REQUEST FOR REASONABLE ACCOMMODATION

Date of Request

Name of Applicant/Resident

Telephone Number

Address

City

State

Zip

1. Please indicate the name of the **disabled household member** who is requesting the accommodation.

2. Please describe the reasonable accommodation you are requesting.

3. Please explain the reason you are requesting this accommodation and how it will provide you with equal opportunity to enjoy our community programs, your unit, and/or common areas.

4. Please have your doctor, health care provider, or other qualified individual verify that your request: (1) is related to your disability; and (2) would provide you with an equal opportunity to enjoy our community or that your disability restricts you from performing this task. (The verification forms are attached to this request for your convenience.)

REASONABLE ACCOMMODATION VERIFICATION

To: Qualified Individual (e.g., counselor, social worker, doctor, rehabilitation center, service agencies, self-help group, clinics, or other entity identified by the person requesting a reasonable accommodation)

_____ has requested that _____ provide the following reasonable accommodation(s):

The Association is required by law to provide reasonable accommodations to disabled applicants/residents that will provide them with **equal opportunity to use and enjoy our community, their unit, and/or common areas**. The Association does **not** provide reasonable accommodations when the request is a matter of convenience or preference only.

Please verify that the above requested accommodation: **(1) is related to the applicant's/resident's disability; and (2) would provide the applicant/resident with an equal opportunity to enjoy our community or that the applicant's/resident's disability restricts them from performing this task.**

I, _____, do / do not **(please circle one)** believe that the above requested accommodation: (1) is related to the applicant's/resident's disability; and (2) would provide the applicant/resident with an equal opportunity to use and enjoy our housing or that the applicant's/resident's disability restricts him or her from performing this task.

Signature

Date

Printed Name

Phone Number

Professional Title (if applicable)

Address

**VERIFICATION OF DISABILITY STATUS
FOR USE WHEN REQUESTING A REASONABLE ACCOMMODATION**

RE: _____

Name of Applicant/Resident

Address

City

State

Zip

Telephone

I authorize the release of the following information relative to my physical or mental impairment, to _____, to verify the need for the reasonable accommodation I have requested.

Signature

Date

Section 504 of the Rehabilitation Act of 1973, as amended, defines Individuals with Disabilities as any persons who:

1. Have a physical or mental impairment that substantially limits one or more major life activities (e.g., caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working); or
2. Have a record of such an impairment (have a history of, or have been misclassified as having a mental or physical impairment that substantially limits one or more major life activities); or
3. Are regarded as having such impairment.

**(NOTE: We are not asking for, nor are you required to disclose, the impairment or any of your medical records or information. The information we are seeking is whether the person signing below believes the applicant meets the definition listed above.)*

CERTIFICATION OF DISABILITY

In my professional opinion, _____ does/ does not (**please circle one**) meet the definition of an Individual with a Disability, as defined above.

Signature

Date

Printed Name and Title

Phone Number

Address

City

State

Zip