REASONABLE ACCOMMODATION

HOUSINGAUTHORITY
SANTA CLARA COUNTY

505 West Julian Street San José, CA 95110 | (408) 275-8770 | TDD: 408-993-3041

The Santa Clara County Housing Authority (SCCHA) is committed to providing reasonable accommodations to persons with disabilities to help ensure an otherwise eligible person receives an equal opportunity to participate in and benefit from its housing programs. Upon request, a reasonable accommodation to change SCCHA policies and procedures will be considered.

Reasonable accommodation requests may be submitted either in writing or verbally at any time to SCCHA; this form is also available on our website: www.scchousingauthority.org

Instructions on submitting a request for Reasonable Accommodation:

1. This form has three pages, including this page.
2. The second page includes a series of questions that must be answered by the Head of Household, or the person who is submitting the request on behalf of the family member with a disability. All requests will be verified by a third party knowledgeable professional. The third page is an Authorization for Release of Information.
3. You must complete both documents, sign the "Authorization for Disclosure or Use of Health Information" form and submit them to SCCHA. If SCCHA does not receive these documents within fifteen (15) business days, your request will be closed due to a lack of response.
4. If the disabled family member is 18 years of age or older, he or she and the Head of Household must sign the "Authorization for Disclosure or Use of Health Information" form. The Head of Household must sign on behalf of a disabled minor requesting the accommodation.
5. If you need assistance in completing the form, or require translation services, contact SCCHA.
6. You may submit your completed forms to SCCHA in any of the following ways:
   - Place them in the Drop Box located outside the SCCHA front lobby doors
   - In person by giving them to lobby personnel
   - Mailed to 505 West Julian Street, San Jose, CA 95110
   - Faxed to 408-993-4001

When all required documentation is received, SCCHA will respond to your request within 15 business days.

REASONABLE ACCOMMODATION REQUEST QUESTIONNAIRE

HOUSINGAUTHORITY
SANTA CLARA COUNTY

Provide the following information:

Head of Household Name: _____

Address: _____

City: _____ Zip Code: _____

Phone Number: _____ Email Address (optional): _____

1. Name of person with disability: _____
2. Is this person a minor (age 17 or younger)? ☐ Yes ☐ No
3. Without providing any details of the disability itself, indicate the type of accommodation requested as a medical necessity: (Please do not submit medical or medication records.)
   - ☐ Separate sleeping room due to medical reasons
   - ☐ Additional room for medical equipment
   - ☐ Additional bedroom for 24-hour personal care attendant
   - ☐ Rent a unit from a relative who is not and will not reside in the unit
   - ☐ Other: _____

   _____

   _____
4. The accommodation is needed because: _____

   _____

   _____

   _____
5. Name of doctor, health care professional, non-medical service agency, or a reliable third party who is in a position to know about the individuals' disability.

   Print Name of Provider: _____

   Title (if applicable): _____

   Address: _____

   Phone Number: _____ FAX Number: _____

   Email Address (Optional): _____

AUTHORIZATION FOR DISCLOSURE OR USE OF HEALTH INFORMATION

HOUSINGAUTHORITY
SANTA CLARA COUNTY

Head of Household: _____ **Entity ID:** _____

Completion of this document authorizes the disclosure and/or use of individually identifiable health information as set forth below. Failure to provide all information requested may invalidate this Authorization.

Patient/ Client Name: _____ **DOB:** _____

I authorize the exchange of health information (as specified below) deemed necessary to complete and verify my application for participation and/or to maintain my continued assistance under the Section 8 Program between the Santa Clara County Housing Authority (SCCHA) and the following person/organization:

Name of Person/Agency: _____

Address: _____

This Authorization applies to the following information (select only one of the following):

- ☐ All health information necessary to evaluate disability-related need for a reasonable accommodation
- ☐ Only the type of health information related to: _____

_____

This Authorization expires 15 months from the date it was signed, unless consent is withdrawn in writing.

Restrictions: California law prohibits the requestor from making further disclosure of my health information unless the requestor obtains another authorization from me or unless such disclosure is specifically required or permitted by law.

My Rights: I may refuse to sign this Authorization. I may inspect or obtain a copy of the health information that I am being asked to disclose. I have a right to receive a copy of this authorization. I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to: SCCHA, 505 West Julian Street, San Jose, CA 95110. My revocation will be effective after 48 business hours from receipt, but will not be effective to the extent that the requestor has acted in reliance upon this Authorization.

I acknowledge and agree that a photocopy of this authorization shall be as valid as the original and may be used for the above stated purposes.

HEAD OF HOUSEHOLD:

_____	_____	_____
Print Name	**Signature**	**Date**

PATIENT:

_____	_____	_____
Print Name	**Signature**	**Date**

If you are signing on behalf of the patient/client, state your legal relationship:

_____

Equal Housing Opportunity