St. Petersburg Housing Authority
Creating Opportunities for Stronger Communities

Address 2001 Gandy Blvd. N.
St. Petersburg, FL 33702
Telephone 727-323-3171
Fax 727-209-6988
TDD 1-800-955.8770
Website www.stpeteha.org

REASONABLE ACCOMMODATION QUESTIONNAIRE

A person with a disability(ies) (or their legal guardian) may request a change, exception or adjustment to St. Petersburg Housing Authority (SPHA) rules, policies, practices, procedures or modifications to its housing units or common areas as a reasonable accommodation. Requesting an accommodation does not affect participation in the program. **This form must be completed and returned to SPHA so your reasonable accommodation request can be processed.** Contact your SPHA property management team or Housing Choice Voucher (HCV) specialist if assistance is needed in completing this form.

Head of Household Name: _____

Address: _____ Phone # _____

Other preferred contact information: _____

Please check the appropriate box, provide the information necessary, sign the bottom, and submit to SPHA.

1. Does anyone in your household need a reasonable accommodation?

☐ No - If **No**, complete number 3 below

☐ Yes - If **Yes**, complete numbers 1a, 1b, 1c, 1d, 2, and 3

1a. Print the name of the family member requiring the accommodation _____

1b. Is the family member under the age of 18? ☐ No ☐ Yes

1c. Describe the accommodation needed _____

_____

_____

1d. Is this request to overturn a negative action taken by SPHA because the family did not comply with program requirements and the reason for not complying was due to a household member's disability? ☐ No ☐ Yes

If **Yes**, how did the disability prevent compliance with the rules and requirements of the program?

(Include any applicable dates) _____

_____

_____

2. Person who can verify the disability and the disability-related need for the accommodation, such as (but not limited to): a licensed physician, physical therapist, psychiatrist, social worker, caseworker, or counselor).

Name: _____

Agency (if applicable): _____

Address: _____

Phone number: (____) _____ Fax number: (____) _____

E-mail (if known): _____

3. **Signature: I certify the above information is correct:**

_____ _____

Signature of Head of Household or Co-head Date

Please submit this completed form to your property manager / HCV specialist. You must also complete the Part I. of the "Reasonable Accommodation – Verification of Need" form for your request to be processed. SPHA will independently verify the information submitted and render a decision on your request.

SPHA
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REASONABLE ACCOMMODATION VERIFICATION OF NEED

Dear Knowledgeable Professional or Other Reliable Third Party:

The individual listed below considers him or herself to be disabled and has asked for an accommodation from this agency to meet certain needs he or she believes are dictated by the disability. The St. Petersburg Housing Authority (SPHA) grants reasonable accommodation requests based in part by verification of need from a knowledgeable professional who has direct experience with an individual's disability. You have been authorized to release information to us regarding the need for an accommodation. Please be aware of the following while completing this request:

- Do not send us the medical records of the individual requesting your verification.
- Do not include any details which disclose the nature or severity of the individual's disability. This information is not necessary to verify the needed requested adjustment.

PART I. HOUSEHOLD MEMBER'S INFORMATION

Last Name	First Name	Middle Initial
Address		

City	State	Zip Code	Daytime Telephone Number ( )

I, _____ authorize _____
(Applicant/Resident/Participant's Name) (Knowledgeable Professional)

to disclose relevant information to SPHA regarding the need for a reasonable accommodation for _____. I understand the information that SPHA obtains will be kept confidential and used solely to determine if an accommodation should be provided. I declare under penalty of perjury under the laws of the State of Florida that the foregoing information is true and correct. (Florida Statute § 837.012.)

_____ _____
Signature of Applicant/Resident/Program Participant Date

Please return completed, signed and dated forms to: SPHA

SPHA Representative Name: _____

SPHA Representative Position Title: _____

Address: _____

Phone / Fax: _____

PART II. THIS SECTION TO BE COMPLETED BY A KNOWLEDGEABLE PROFESSIONAL OR OTHER RELIABLE THIRD PARTY

Name of individual seeking verification: _____

A "disability" is defined as a physical or mental impairment which limits one or more of a person's major life activities[1], a record of having such an impairment, or being regarded as having such impairment.

1. Does this individual have a disability, as defined above? Yes____No_____

2. If yes, does this individual, because of this disability, need a reasonable accommodation made to either their unit, or other parts of the housing complex, or to house rules, policies, practices, or services of the SPHA to have an equal opportunity to use and enjoy his or her dwelling? **Yes___ No**

3. If yes, please describe the accommodation needed (which must directly relate to the accommodation requested.
Changes must be necessary, NOT only desirable):

_____
_____
_____
_____
_____

Use separate sheet to provide additional information (please print clearly)

[1] Major life activities include, but not limited to: performing tasks, caring for oneself, walking, talking, seeing, hearing, breathing, learning, or working.

PART III. KNOWLEDGEABLE PROFESSIONAL OR OTHER RELIABLE THIRD PARTY INFORMATION

I declare under penalty of perjury under the laws of the State of Florida that the foregoing information is true and correct. (Florida Statute § 837.012.)

FRAUD AND FALSE STATEMENTS

Title 18, Section 1001 of the U.S. Code states that a person who knowingly and willingly makes false and fraudulent statements to any department of the United States Government, the Department of Housing and Urban Development (HUD), a public housing authority (PHA), and any owner (or employee of HUD, the PHA, or the owner) may be subject to penalties that include fines and/or imprisonment.

I understand that I may be contacted by the SPHA to verify the information I have provided or to provide further information/clarification regarding this request. Furthermore, I understand that I may be contacted or otherwise subpoenaed to provide testimony in a court of law, administrative hearing and/or other legal action with respect to the information I have provided within or related to this document. By signing this document, I certify under penalty of perjury that the information and statements I have provided as part of and/or in support of this request for a reasonable accommodation are to the best of my knowledge true and accurate. I also certify that I have reviewed all attached documents pertaining to this request.

Knowledgeable Professional or Other Reliable Third Party's Signature **X**			
Knowledgeable Professional or Other Reliable Third Party's Name (Print)		License or Certificate Number/Issuing State	
Title:			
Address			
City	State	Zip Code	Telephone Number ( )