GREENFIELD
HOUSING AUTHORITY
1 Elm Terrace
Greenfield, MA 01301
413-774-2932 (P) 413-772-0616 (F)

**Notice to All Applicants and Residents: Reasonable Accommodations and Modifications are Available for Applicants and Residents with Mental and/or Physical Disabilities**

Greenfield Housing Authority (GHA) does not discriminate against applicants or residents on the basis of mental (including psychiatric) or physical disabilities. In addition, the GHA has an obligation to provide "reasonable accommodations" and "reasonable modifications" on account of a disability if an applicant or resident or a household member is limited by the disability and for this reason needs such an accommodation or modification. A reasonable accommodation is a change that the GHA can make to its rules, policies, practices, or services, and a reasonable modification is a change an GHA can make to its facilities (including physical alterations to the housing unit or public or common use areas) that will assist an otherwise eligible person with a disability to have equal opportunity to use and enjoy the housing or common or public use areas or to participate fully in the GHA's programs, activities, or services. Such changes may not be reasonable if they are not financially and programmatically feasible for the housing authority.

An applicant or resident household which has a member with a mental and/or physical disability must still be able to meet essential obligations of tenancy (for example, the household must be able to pay rent, to care for the apartment, to report required information to the GHA, and to avoid disturbing neighbors), but an accommodation or modification may be the basis by which the household is able to meet those obligations of tenancy.

The GHA's Accommodation Coordinator is the Executive Director or his/her designee. If you need an accommodation or modification because of a disability, please complete the attached form and return it to the GHA. Upon reasonable request by the GHA, you must also submit documentation verifying the existence of a disability and the disability-related need for the accommodation or modification. Within thirty (30) calendar days of receipt of your request and documentation, the Accommodation Coordinator will contact you to discuss what the GHA can reasonably do to provide you an accommodation or modification on account of your disability.

If you or a member of your household has a mental and/or physical disability, and as a result needs an accommodation or modification, you, the household member, or authorized representative, may request it at any time. However, you are not obliged to make such a request, and if you prefer not to do so that is your right.

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Request for Reasonable Accommodations/Modifications

To: Accommodation Coordinator

Greenfield Housing Authority

1 Elm Terrace, Greenfield, MA 01301

From: _____
Applicant or Resident Name (please print) Control Number

_____
Address

_____
Town/City, State, Zip

(____)_____
Area Code/Telephone Number

1. On account of my disability, I request the following be done in order to permit me to have equal opportunity to use and enjoy the housing or public or common use areas or to participate fully in the Housing Authority's programs, activities, or services: (Describe)

_____

_____

_____

2. This request for a reasonable accommodation/modification is necessary so that I can:

_____

_____

_____

3. Documentation needed to verify the existence of my disability and my disability-related need for the accommodation/modification is attached. (Attach appropriate documentation)

I attest that the foregoing information is true and correct.

_____ SIGN HERE _____

Signature of Applicant or Resident (or authorized representative) Date

**I authorize Greenfield Housing Authority to verify that I have a disability/handicap and have the need for the reasonable accommodation I have requested. In order to verify this information, the GHA may contact the following third party medical/mental health professional familiar with my disability.**

**Professional to contact to verify the need for the requested accommodation:**

**Name of Professional: _____**
**Title: _____**
**Agency, Facility, or Institution (if any): _____**
**Phone#_____**
**Address: _____**

**Do you grant the GHA permission to obtain information from your medical professional? Yes or No (Please circle)**

**I understand that the information obtained by the GHA will be kept completely confidential and used solely to make a determination on my reasonable accommodation request. Please return the form as promptly as possible.**

_____ SIGN HERE _____

**Head of Household Signature** **Date**

_____ _____

**Disabled family member Signature if over age 18** **Date**

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**Date:** _____

**Dear**_____

I have applied for a reasonable accommodation from the Greenfield Housing Authority (GHA) and request that you fill out the following certification. Enclosed is a copy of my Request for Reasonable Accommodation.

Patient's Name: _____
Address: _____
Telephone:_____
Signature:_____ SIGN HERE Date: _____

***Residents/Applicants Stop here***

Verification of Disability by Physician or Other Professional
for Reasonable Accommodation/Modification Request

The Greenfield Housing Authority (GHA) may request verification that an applicant/resident has a disability to determine whether the applicant/resident needs a reasonable accommodation in the GHA's rules, policies, practices or services, or needs a reasonable modification of the leased premises or public or common use areas, in order to have equal opportunity to use and enjoy the leased premises or the public or common use areas, or to participate fully in the GHA's programs, activities, or services. The above-named applicant/resident has authorized your release of the requested information. We would appreciate your prompt response to the questions on the reverse side of this letter. If you have questions, please contact our office. Thank you for your anticipated cooperation.

Sincerely,

Jack Redman
_____

Executive Director and/or Reasonable Accommodation Coordinator

**The remainder of this form is to be completed by medical personnel.**

The page is to be completed by medical personnel.

Name of Physician or other professional: _____

Profession: _____

Address

_____

_____

Date_____

The following proposed reasonable accommodation(s)/reasonable modification(s) to provide the applicant/resident equal opportunity to use and enjoy the LHA's housing, programs, etc. is (are) under consideration by the GHA:

_____
_____
_____
_____

THE FOLLOWING TO BE COMPLETED BY PHYSICIAN (OR OTHER PROFESSIONAL):

In my opinion, the patient has a disability, which is defined under law as a physical or mental impairment that substantially limits one or more major life activities. *

[ ] YES [ ] NO

*Note: Determination of whether a physical or mental impairment substantially limits a major life activity is to be made without regard to the ameliorative effects of mitigating measures (e.g., assess substantial limitation of a major life activity, including the operation of a major bodily function, without considering the benefit of medication, assistive devices, etc., to the individual). Furthermore, an impairment that is episodic or in remission is a disability if it would substantially limit a major life activity when active.

In my opinion, the patient's disability requires that the GHA make reasonable accommodations in order for the patient to have equal opportunity to successfully use and enjoy the GHA's housing, programs, etc.

[ ] YES [ ] NO

Please describe how the accommodation your patient has requested relates to their disability and verify that the enclosed description of needed changes requested by your patient are necessary for equal enjoyment of the programs opportunity as a result of their disability. (Please use the space provided below or attach your response to this form*).

The page is to be completed by medical personnel.

*Note: please only provide information that demonstrates there is a relationship between a disability verified by a "yes" response to question 1 above and the need for the proposed reasonable accommodation/modification. Please do not otherwise provide information as to the nature or severity of the disability.

_____

_____

_____

_____

If specialized equipment is recommended, please describe the equipment, where it may be obtained, does it require its own room and any specifications related to the equipment:

_____

_____

_____

The need for this accommodation is:

[ ] Permanent

[] Temporary: Expected to last 1 year or more _____ Less than 1 year _____

Please indicate how current your knowledge is regarding this individual:

[] Within the last six months [] Prior to the last six months

CERTIFICATION: I certify that the information provided above represents my professional judgment and is true and correct to the best of my knowledge and belief.

_____ _____

Signature of Physician or Professional Title

Name: _____ Address: _____

Telephone #: _____ Date: _____

**You may be called to testify in a court of law concerning the information provided in this form.**