GAINESVILLE
Housing Authority
Where Housing Matters

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Pamela Davis, *Chief Executive Officer*

GainesvilleHousingAuthority.org

Request for Reasonable Accommodation Form

Date of Request:	
Requested By: (Print Name)	
Address:	
Phone Number:	
Person with Disabilities (if different from above):	
GHA Receipt Date / Tenant Number	

This form is provided in accordance with the Fair Housing Act (42 U.S.C. § 3601 et seq.), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794), and the Americans with Disabilities Act (ADA). Gainesville Housing Authority (GHA) provides reasonable accommodations to applicants, tenants, and program participants with disabilities to ensure equal access to housing and programs. In addition, the information obtained by GHA will be kept confidential or redacted to remove health-related information under HIPPA, and used solely to make a determination for the reasonable accommodation request.

1. **Unit Size/ Bedroom Accommodation:**
   ☐ Separate bedroom for disabled family member listed above.
   ☐ Initial or annual request for **additional bedroom for medical equipment**, *e.g., bariatric beds, ventilators or large respiratory equipment, home dialysis machines, patient lifts (floor-based or mounted), complex nutritional support supplies (IV/feeding pumps), large therapy and monitoring equipment.*
   ☐ Other: _____
2. **Physical Modifications:**
   ☐ Grab bars in bathroom shower or hallway
   ☐ Handrails
   ☐ Lowered cabinets
   ☐ Roll-in shower
   ☐ Visual alarms
   ☐ Doorway widening
   ☐ Lever door handles
   ☐ Lowered countertops
   ☐ Other: _____
3. **Unit Location / Accessibility:**
   ☐ First-floor unit
   ☐ Near elevator
   ☐ Near parking
   ☐ Wheelchair accessible unit
   ☐ Other: _____
4. **Exterior Modifications:**
   ☐ Wheelchair ramp
   ☐ Accessible parking
   ☐ Other: _____

5. **Special Features:**
   ☐ Air conditioning (medical)
   ☐ Heating requirements
   ☐ Visual doorbell
   ☐ Other: _____

6. **Policy / Procedure Change:**
   ☐ Specify: _____
   _____
   _____

7. **Communication Change:**
   ☐ Large print
   ☐ Email
   ☐ TTY
   ☐ Interpreter _____
   ☐ Assistance with completing forms
   ☐ Other: _____

8. **Initial or Annual Request for Live-in Aide -** *Please check or complete all applicable items*:
   - Does the patient have a physical, mental, or medical impairment that substantially limits one or more major life activities? ☐ Yes ☐ No
   - Is a live-in aide medically necessary for the patient's health, safety, or ability to live independently? ☐ Yes ☐ No
   - The patient requires assistance with:
     ☐ Activities of Daily Living (bathing, dressing, eating, toileting)
     ☐ Instrumental Activities (medications, transportation, housekeeping)
     ☐ Mobility/transfer assistance
     ☐ Monitoring for medical or safety needs
     ☐ Cognitive supervision
     ☐ Other: _____
   - Frequency of assistance required:
     ☐ Intermittent
     ☐ Daily
     ☐ Overnight supervision
     ☐ Continuous / 24-hour support
   - Can the patient safely live alone without a live-in aide? ☐ Yes ☐ No
   - Expected duration of need:
     ☐ Temporary — Estimated length of time: _____
     ☐ Long-term/Permanent
   - Without a live-in aide, would the patient's health, safety, or housing stability likely be at risk?
     ☐ Yes ☐ No

9. **Assistance Animal:**
   ☐ Service dog trained to perform specific tasks related to a person's disability.
   ☐ Emotional support/assistance animal, e.g., dog, cat, bird, rabbit, hamster, fish, etc. The animal must provide emotional support or other disability related assistance and supported by reliable documentation.

10. **Additional Request(s)**: _____

Requestor's Signature: _____

Medical Provider Certification

☐ **Individual has a disability** that affects major life activities as defined under the Americans with Disabilities Act (ADA) as a physical or mental impairment that substantially limits one or more key life functions, e.g., walking, seeing, hearing, speaking, breathing, learning, concentrating, and working, as well as major bodily functions like immune system, brain, or respiratory function.

☐ **Individual DOES NOT have a disability** as defined under the ADA.

If the person has a disability, then there must be a **nexus or connection between the disability and the request**.

- ☐ Nexus exists
- ☐ No nexus exists

Please explain the nexus below:

_____

_____

_____

_____

Medical Service Provider Name: (Print) _____ **Title:** _____

Florida License #: _____ **Phone:** _____

Agency/Facility Name: _____

Address: _____

Medical Service Provider Signature: _____ **Date:** _____

EQUAL HOUSING OPPORTUNITY