

REQUEST FOR ACCOMMODATION

Please fill out this form to identify what you are requesting. The request will be sent to your provider to verify that the request is related to the disability indicated and to provide equal opportunity to use and enjoy our housing programs.

Head of Household: _____ Date of request: _____
Social Security #: _____ Telephone: _____
Address: _____ City/State/Zip code: _____

1. Request for Accommodation: (who, Name of household member)

2. Accommodation requested: (What) _____

3. Need for requesting this accommodation – provide no medical information:
(Why) _____

I authorize the Kearney Housing Agency to verify that I (or my family member) have a disability and have the need for the specific accommodation I have requested. In order to verify this information, the housing authority may contact the following professional:

Name: _____ Phone Number: _____

Title of Professional or Expert: _____

Agency, Facility or Institution: _____

Address: _____ City/St/Zip: _____

I certify that the information in this Request for Accommodation is true and accurate. I give Kearney Housing Agency permission contact my medical and/or service professional about my disability and accommodation request.

Printed Name: _____ Signature: _____ Date: _____

Accommodation Completed

Tenant/Applicant Name Printed: _____ Date: _____

Tenant/Applicant Signature: _____

KHA Representative Signature: _____ Date: _____

Equal Opportunity Housing

KHA does not discriminate on the basis of handicap, race, color, religion, sex, familial status, gender identity or sexual orientation, or national origin in the admission or access to, or treatment or employment in its federally assisted programs and activities.

The services of a Spanish speaking interpreter are provided to all applicants and residents, with no cost to the applicant or resident.

N: Request for Accommodation – 3/09

