

Section 504 Request for Reasonable Accommodation Live-In Aide

Instructions

Purpose of this form: In accordance with Section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act (ADA) and the Fair Housing Act, it is the policy of [Name of Housing Provider] to make reasonable accommodation in rules, policies, practices, and/or services when such accommodation may be necessary to provide a person with a disability the equal opportunity to use and enjoy a program or dwelling under the program.

If you or anyone in your household is a person with disabilities, and you require a live-in aide to reside in the unit with you to administer care. This person(s) will occupy a bedroom in the unit and will provide around the clock assistance to you.

Note: A live-in aide must meet the following HUD definition: *a person who resides with one or more persons with disabilities and who:* 1) is determined to be essential to the care and well-being of the person; 2) is not obligated for the support of the person(s); and 3) would not be living in the unit except to provide the necessary supportive services.

Please complete the following information and return to the property management office or the regional office. If you need this document in a different language or larger font or if you need another reasonable accommodation in order to complete



[insert company letterhead]

this form, please contact the property management office, the regional office, or the Section 504 Coordinator.

The 504 Coordinator is:

Name: [insert]

Address: [insert]

Phone: [insert]

TDD/TTY or Colorado Relay: [insert]

E-Mail: [insert]



Request for Reasonable Accommodation - Live-In Aide

Date of Request: _____

Head of Household Name: _____

Name of Household member requesting the accommodation: _____

Best way to contact you for additional information: _____

Full Address: _____

1. I am requesting accommodation for a live-in aide because:

- ☐ I require a live-in aide to reside in the unit with me to administer care. This person will reside in the unit and will provide around the clock assistance to me.

2. If your disability is obvious or otherwise known to [Name of Housing Provider], and if the need for the requested accommodation is also readily apparent or known, no further verification will be required. If the disability is not obvious, or the nexus between the disability and the requested accommodation is not obvious, please list the contact information of the knowledgeable professional who can verify that you have a disability warranting the accommodation(s).



[insert company letterhead]

Name: _____ Title: _____

Address: _____

Telephone Number: _____ Fax Number: _____

3. Release of Information: I certify that the information provided on this form is true and accurate. I give management permission to discuss the requested accommodation with the knowledgeable professional listed above. Information obtained under this consent is limited to information that is no older than 12 months and that is necessary to evaluate the disability-related need for the accommodation. Medical records will not be accepted or retained in the participant file. The knowledgeable professional listed will receive a copy of this form.

Signature of Applicant/Resident

Date

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 or employee of the United States Government, HUD, a Public Housing Authority or a Property Owner may be subject to penalties that include fines and/or imprisonment.

Office Use Only: RA Log #: _____

