HOUSING AUTHORITY OF THE
COUNTY OF SAN BERNARDINO

Request for Reasonable Accommodation

Date of Original Request _____ ☐ Verbal ☐ Written (check one)

Date Form Completed (If Different From Date of Original Request): _____

Family Head of Household: _____

Address: _____

Cell Phone: _____ Home Telephone: _____

Email Address: _____

☐ Medical Documentation Attached. *You do not have to attach medical documentation to this request to invoke your rights to reasonable accommodation. Verifications may be obtained after you submit your request, but before a decision is made.*

I am requesting the following reasonable accommodation(s):

_____ Live-in Aide

_____ Additional Bedroom

_____ Assistance required completing paperwork

_____ In-home appointment (due to medical condition/age)

_____ Translation service Language needed: _____

_____ Other: _____

_____

_____

(Please feel free to attach further justification)

_____ _____ _____

Requestor's Signature Phone Number Date

WARNING: Title 18, Section 1001 of the United States Code, states that a person is guilty of a felony for knowingly and willingly making false or fraudulent statements to any Department or Agency of the United States Government. Making false statements is a felony under California State Law (Penal Code Sections: 115, 118, 487i and 532) and may result in criminal charges including Perjury, Grand Theft, Filing False Documents with a Public Office and Obtaining Money Under False Pretenses.

List the name of the health care provider who can verify the disability and the need for the accommodation requested. This should be the individual providing professional services that relate to the disability.
Name: _____ Position: _____

Address: _____

Phone: _____ Fax: _____

FOR OFFICE USE ONLY

_____	_____	_____
Print Name	Signature	Date Approved / Denied

Please return completed, signed and dated forms to:

Attention:
Section 504 Coordinator
Housing Programs Office
672 S. Waterman
San Bernardino, California 92408

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