HOUSING COMMUNITY ECONOMIC
LACDA
Los Angeles County Development Authority

MAIN OFFICE
700 W. Main Street, Alhambra, CA 91801
Tel: 626-262-4510 TDD: 626-943-3898
www.lacda.org

Carmelitos Management Office - 1000 Via Wanda Ave., Long Beach, CA 90805

REQUEST FOR A REASONABLE ACCOMMODATION / REASONABLE MODIFICATION

The Los Angeles County Development Authority (LACDA) provides reasonable accommodations/modifications for any member of your household who has a disability.

You must date and sign your name at the bottom and return this form to your management office. If you need assistance, you may contact your management office.

Date of Request: _____ Applicant/Tenant ID: _____

Head of Household or Applicant Name: _____ Phone: _____

Resident Address: _____

1. Describe the accommodation/modification you are requesting (please be very specific):

2. Describe why this accommodation/modification is needed and how it relates to a disability:

3. List the name of the health care provider who can verify the disability and the need for the accommodation/modification requested. This should be the individual providing professional services that relate to the disability.

   Name: _____ Position: _____

   Address: _____

   Phone: _____

On the VERIFICATION OF NEED FOR REASONABLE ACCOMMODATION/MODIFICATION form, you must sign the Authorization to Release Information and have a health care provider complete the form. Please return this form and the VERIFICATION OF NEED FOR REASONABLE ACCOMMODATION/MODIFICATION form to your management office.

Signature: _____ **Date:** _____
Head of Household or Applicant Signature

TO BE COMPLETED BY HOUSING OPERATIONS DIVISION SITE STAFF:

Received By (Print Name): _____ **Date:** _____

Site Name: _____ **HOH Name:** _____

Property Manager Signature: _____ **Date:** _____

VERIFICATION OF NEED FOR A REASONABLE ACCOMMODATION / REASONABLE MODIFICATION

Dear Health Care Provider:

The individual listed below considers themselves to be disabled and has asked for an accommodation/modification from this agency to meet certain needs he or she believes are dictated by the disability. The LACDA grants reasonable accommodation/modification requests based in part by verification of need from a health care provider who has direct experience with an individual's disability. You have been authorized to release information to us regarding the need for an accommodation/modification. In order to maintain client confidentiality, we require this form to be returned to the LACDA.

PART I. APPLICANT/RESIDENT/PATIENT INFORMATION

Last Name	First Name	Date of Birth

Address

City	State	Zip Code	Daytime Telephone Number
			( )

I, _____, authorize _____
(Resident's or Applicant's Name) *(Health Care Provider)*

to disclose relevant information to the LACDA regarding the need for a reasonable accommodation/modification. I understand the information the LACDA obtains will be kept confidential and used solely to determine if an accommodation/modification should be provided. I declare under penalty of perjury under the laws of the State of California that the foregoing information is true and correct. (California Penal Code Section 118.)

Signature **X** _____ Date _____

PART II. THIS SECTION TO BE COMPLETED BY A LICENSED OR CERTIFIED HEALTH CARE PROVIDER

A "disability" is defined as a physical or mental impairment which limits one or more of a person's major life activities, a record of having such an impairment, or being regarded as having such an impairment.

1. Does this individual have a disability, as defined above? Yes____ No____.

2. If yes, does this individual, because of this disability, need a reasonable accommodation/modification made to either their unit, or other parts of the housing complex, or to house rules, policies, practices, or services of the LACDA to have an equal opportunity to use and enjoy his or her dwelling? Yes___ No___

3. If yes, please describe the accommodation/modification needed (the accommodation/modification must directly relate to the accommodation/modification requested. Changes must be necessary, NOT only desirable):

PART III. HEALTH CARE PROVIDER INFORMATION

I declare under penalty of perjury under the laws of the State of California that the foregoing information is true and correct. (California Penal Code Section 118.)

Health Care Provider's Signature **X**	Date of Exam
Health Care Provider's Name (Print)	License or Certificate Number/Issuing State

Place Office Stamp In This Space or Attach Office Letterhead

Title

Address

City	State	Zip Code	Telephone Number
			( )

LACDA Completes This Section

Reviewed By	Date
Field Office	**Form Received Date**