REQUEST FOR REASONABLE ACCOMMODATION

YOLO COUNTY HOUSING
147 West Main Street, Woodland, CA 95695

Return to: CLIENT SERVICES- clientservices@ych.ca.gov: Isaac Blackstock (530) 669-2259/ Lizbeth Vital (530) 662- 5428

___ New request ___ Renewal ___ Port in Housing specialist:_____

Instructions: Complete this form if you, or a member of your family, is a person with a disability and you wish to request a change, exception, or adjustment in a Yolo County Housing (hereinafter, YCH) rule, policy, practice, or service in order to have an equal opportunity to use and enjoy housing or housing assistance administered by YCH. **If you need assistance completing this form, please contact CLIENT SERVICES DIRECTLY.**

Household File Name: _____ **Phone/TDD #:**_____
Street Address/City/Zip Code

Address:_____ **Email:**_____

1. The following family member, _____ born _____ *(optional)*, has a physical or mental impairment that limits one or more major life activities (or a record of having such an impairment, or of being regarded as having such an impairment).

2. State the accommodation needed in order for this person to have an equal opportunity to use and enjoy housing or housing assistance administered by YCH:

_____

_____

3. Describe how this accommodation will allow this person to have an equal opportunity to use and enjoy housing or housing assistance administered by YCH:

_____

_____

YCH grants requests for a reasonable accommodations/modifications based on an identifiable relationship, or nexus, between the requested accommodation and the person's disability. **List the name and contact information** of the knowledgeable person who can verify the disability-related need for the accommodation. The person you identify should be the individual providing services that relate to the family member's physical or mental impairment (medical professional, social service provider, etc).

Name of Physician/Health Care Provider/Professional: _____

Address:_____
Street Address/City/Zip Code

Phone Number: _____ **FAX Number:** _____

Authorization to Release Information: I **authorize** the Care Provider listed above to disclose the information requested on this form to YCH regarding the need for a reasonable accommodation/reasonable modification. **I understand** the information YCH obtains will be kept confidential and used solely to determine if a reasonable accommodation and/or modification should be provided. **I understand** that YCH will process this request by communicating directly with the care provider identified above and that I will be notified in writing of the determination. **I understand** that YCH may, at its sole discretion, periodically reassess the need for any granted reasonable accommodation. This authorization expires 90 days from the date of signature below.

_____	_____	_____
Printed Name of Family Member	Signature of Family Member (if 18 years or older)	Date
_____	_____	_____
Printed Name of Head of Household	Signature of Head of Household	Date