

REASONABLE ACCOMMODATION VERIFICATION

Date: _____

To: _____ Title: _____

Individuals qualified to complete this form are Counselors, Social Workers, Physicians, Psychiatrists identified by the person requesting a reasonable accommodation.

_____ has requested that
(Client Name)

_____ in Washington, D.C. provide the following accommodation(s):
(Shelter/Housing Program)

DC Homeless Service providers are required by law to provide reasonable accommodations to applicants/residents with disabilities that will provide them with equal opportunity to use and enjoy our programs, their unit and/or common areas. Homeless Service programs do not provide accommodations when the request is a matter of convenience or preference only. Please verify that the above accommodation: (1) is related to the applicant's/resident's disability; and (2) would provide the applicant/resident with an equal opportunity to enjoy our programs or that the applicant's/resident's disability restricts them from performing this task.

I, _____, do/do not (please circle one) believe and it is my professional opinion that the above requested accommodation: (1) is related to the applicant's/resident's disability; and (2) would provide the applicant/resident with an equal opportunity to use and enjoy the program or that the applicant's/resident's disability restricts them from performing this task.

Signature _____ Date _____

Printed Name _____ Telephone Number _____

Address _____ City _____ State _____ Zip Code _____

Because Reasonable Accommodations are time sensitive, please return this form no later than **14** calendar days after its receipt to:

Shelter or Housing Program Director, Program Address

The information shared in this form will be used to determine whether to grant the accommodation request and may also be used should legal action be required.