

REQUEST FOR AN ACCOMMODATION

Date of Request _____

Social Security Number of Requester _____

Name of Applicant/Resident _____

Telephone Number _____

Address _____

City _____

State _____

Zip Code _____

Shelter or Housing Program _____

1. Please indicate the name of the person with a disability requesting the accommodation.

2. Please describe the accommodation you are requesting.

3. Please explain the reason you are requesting this accommodation and how it will provide you with equal opportunity to enjoy our programs.

4. I, _____ authorize my shelter provider to verify that myself or someone in my household has a disability and needs the accommodation I requested. The shelter provider will contact the following medical or mental health professional or licensed service agency that provides services to me and ask for written documentation on the Verification Form to support my request.

Client Signature: _____

REQUIRED INFORMATION:

Name: _____ Title _____

Agency/Institution and address: _____

Fax _____ Phone _____

If you need assistance with this form or have any additional questions, please contact: (insert name of provider's staff contact).

For Shelter Staff Use Only: If a client requires a PHYSICAL ACCESSIBILITY that your agency cannot provide return this form to: Cornell Chappelle, Chief of Program Operations, The Community Partnership for the Prevention of Homelessness 801 Pennsylvania Avenue, SE, Suite 360 Washington, DC 20003 V: (202) 543-5298 Fax: (202) 543-5653