Stark Metropolitan Housing Authority
400 Tuscarawas Street East
Canton, OH 44702

PH: 330-454-8051 FX: 330-454-8065 Ohio Relay Service 1-800-750-0750

NOTICE OF RIGHT TO REASONABLE ACCOMMODATION

If you have a disability and as a result of your disability you need….

- a change, an exception, or adjustment in the rules or policies, practices, services that would give you an equal chance to enjoy or participate in a Public Housing or Section 8 Program; or
- a change in the way Stark Metropolitan Housing Authority ("SMHA") communicates with you or gives you information.

You may ask for a Reasonable Accommodation.

If you have a disability and verification from a qualified third party professional is provided to show that your request relates to your disability, then SMHA will approve your reasonable accommodation request. However, a request can be denied if it fundamentally alters the nature of SMHA's operations or imposes an undue financial and administrative burden. Additionally, a request that would cause or causes a direct threat to the health and/or safety of other residents and/or SMHA staff will not be granted a reasonable accommodation.

You may ask your property manager for a Request for Reasonable Accommodation form. The forms are also available at the Central Office (located at 400 Tuscarawas Street East, Canton, OH 44702) from the Section 504 Coordinator, the Intake Department or your Section 8 Reviewer. Note: All information you provide regarding your reasonable accommodation request will be kept confidential and used only to help you have an equal opportunity to participate in SMHA's housing programs. If you need help filling out a Request for Reasonable Accommodation form or if you want to give SMHA your request in a way other than the form, please let SMHA know.

You will receive a response within 30 days of all necessary information being reviewed including the qualified third party professional's verification unless there is a delay in getting the information to SMHA or you agree to a longer time. SMHA will let you know if more information is needed or SMHA will talk to you about other ways to meet your needs. Additionally, if the disability is obvious, SMHA does not need third party verification of the disability. For example, if you or a household member are in a wheelchair and you request a ramp, SMHA will not need third party verification to make a decision regarding the request.

If you disagree with the decision, you can request an informal meeting. Upon your request, a informal meeting will be scheduled and a SMHA employee or designee that was not involved in the decision will listen to information about your request. After the informal meeting, the SMHA employee or designee will make a decision to uphold or reverse SMHA's decision. If you and/or SMHA do not agree with the decision, you and/or SMHA can request a formal hearing before a Third Party Hearing Officer. Feel free to contact the Section 504 Coordinator for more information by calling 234-214-4262.

****Requested Accommodations and/or Modifications that obviously meet the need of the requestor need not be verified by a third party professional.**

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REQUEST FOR A REASONABLE ACCOMMODATION

Name: _____ Phone: _____

Address:_____

Email: _____

1. A disbility is defined as a physical or mental impairment that substantially limits one or more major life activities; a record of having such an impairment; and being regarded as having such an impairment.

   The term "major life activity" mean those activities that are of central importance to daily life, such as seeing, hearing, walking, bathing, performing manual tasks, caring for one's self, learning and speaking. This list is not exhaustive. The following member of my household has a disability:

   Name of household member: _____

2. As a result of my/my family member's disability, the following change or changes are requested so that we can participate fully and equally in the Section 8 and/or the Public Housing Programs. **Check the kind of change(s) you need.**

   ☐ A change in the way we communicate with you

   ☐ A change in the following rule, policy, services or procedure:

   _____Pet Policy _____Transfer _____Live-in Aide _____Rental Payment Accommodation

   _____Placement _____Designated Parking _____Lawn Care/Snow Removal

   ☐ A modification to my unit:

   _____Grab Bars _____Walk-in Shower _____Roll-in Shower _____Wheelchair Ramp

   _____Devices for Hearing/Visual Impairment

   If Accommodation/Modification is not listed please describe: _____

3. _____
   _____
   _____
   _____

4. What alternative accommodation could meet the same need should the request made be unavailable or deemed unreasonable?

   _____
   _____
   _____

VERIFICATION OF NEED
FOR REASONABLE ACCOMMODATION/MODIFICATION

This form is an authorization for release of information. Please provide the name of a doctor or other medical professional, a peer support group, a non-medical service agency, or a reliable third party who is in a position to know about the individual's disability and who can verify the disability and the need for the accommodation.

Name:_____ Phone:_____

Address:_____

I give SMHA permission to contact the above individual for purposes of verifying that I or a family member has a disability and need the reasonable accommodation/modification requested above. I understand that the information that SMHA obtains will be kept completely confidential and used solely to determine whether SMHA will provide an accommodation or unless disclosure is required by Law.

Signed: _____ Date: _____

TO BE COMPLETED BY QUALIFIED THIRD PARTY PROFESSIONAL

1. In my opinion as a qualified third party professional, the requestor has a disability as defined below:

   A. A physical or mental impairment that substantially limits one or more major life activities.
   B. A record of having such an impairment; and
   C. Being regarded as having such an impairment.

   ☐ Yes ☐ No

2. In my opinion, the requestor's **disability requires** that **the stated accommodation** is necessary in order for the tenant to have the same access or benefit from the program that a non-disabled person would have.

   ☐ Yes ☐ No ☐ Cannot Verify

Please describe how the requested accommodation would assist the individual with his/her disability without providing the medical details or diagnosis of the individual:

_____

_____

_____

_____ _____
Signature Date

_____ _____
Printed Name Phone

For Office Use Only: AMP#_____ Asset Manager: _____