Corvias
PROPERTY MANAGEMENT

REASONABLE ACCOMMODATION AND MODIFICATION REQUEST FORM

Resident Name:

Date:

Address:

Phone:

Email Address:

GENERAL INFORMATION

Reasonable Accommodation: Change in an existing policy or practice that is necessary for a person with a disability to fully use and enjoy leased housing.

Reasonable accommodations are paid for by property management. A necessary and appropriate reasonable accommodation will be approved unless it causes an undue burden or a threat to health and safety.

Reasonable Modification: Alteration to the physical structure of the housing unit or overall property that is necessary for the person with a disability to fully use and enjoy the housing.

Reasonable modifications, if approved, are paid for by the individual requesting the modification. The requester may, in certain circumstances be required to restore the property to its original condition.

DISABILITY

Do you have a mental or physical disability, a history of such a disability, or are you perceived as having a disability that limits one or more major life activities?

☐ Yes ☐ No

DESCRIPTION OF REQUESTED ACCOMMODATION OR MODIFICATION

Explain the reasonable accommodation or modification that you are requesting:

NECESSITY OF THE REQUESTED ACCOMMODATION OR MODIFICATION

Why do you need the requested accommodation or modification because of your disability?

VERIFICATION

Please indicate the name and contact information for a treating doctor, therapist, social worker or other health care professional who can verify that you have a qualifying disability and that the requested accommodation/modification is necessary because of your disability.

Professional's Name:

Professional's Address:

Corvias
PROPERTY MANAGEMENT

Professional's Contact Number:

Attach documentation from medical provider stating the nature of the condition for which accommodation/modification is being requested and describes how the disability directly relates to the accommodation/modification requested.

SUBMITTING THE REASONABLE ACCOMMODATION OR MODIFICATION REQUEST

The completed Reasonable Accommodation and Modification Request Form, along with required supporting documentation should be submitted to the Manager at the community office. If you need assistance to complete the form, please contact the Manager during office hours.

PROCESS FOR CONSIDERING THE REASONABLE ACCOMMODATION OR MODIFICATION REQUEST

After receiving your reasonable accommodation or modification request, the Community Manager will respond within 5 days, unless there is a problem getting the information needed or unless you agree to a longer time. We will let you know if we need more information or verification from you.

If we cannot approve your request, we will explain the reasons and explore with you other ways to meet your needs. You can give us more information if you think that will help. We will try to work with you to find a way to accommodate your needs.

CONFIDENTIALITY

All information you provide will be kept confidential and be used only to help you have an equal opportunity to enjoy your leased housing, the common areas, and programs offered on site.

DISPOSITION

☐ Approved ☐ Not Approved ☐ Alternate Approved

IF NOT APPROVED OR ALTERNATE APPROVED

Community Manager explanation for decision is outlined below. If there is a requirement to restore property to its original condition prior to vacating, the Community Manager will outline below.

Agreed:

_____ _____

Community Manager

Tenant/Applicant

Corvias
PROPERTY MANAGEMENT

MEDICAL VERIFICATION MEMO

Dear Corvias:

_____ is my client/patient. I am familiar with his/her history and disability-related functional limitations. S/he meets the definition of disability under the federal, state, and local fair housing laws.

To enhance his/her ability to live independently and to fully use and enjoy his/her dwelling, I hereby verify that _____ requires the following modification/ accommodation(s) listed below. These modification/ accommodation(s) will assist him/her with the functional limitations relating to his/her disability.

NOTE: Please distinguish between **required** and **recommended** modification/ accommodation(s).

_____ _____
Title and Name of Professional Date

_____
Signature of Professional

_____
Name and Address of Medical Facility/Clinic

_____
Phone Number