

GARFIELD COUNTY HOUSING AUTHORITY

1430 RAILROAD AVENUE, UNIT F

RIFLE, CO 81650

(970) 625-3589 or (888) 627-3589

Fax (970) 625-0859 * TTY (800) 659-2656

www.garfieldhousing.com

Head of Household: _____ Today's Date: _____

Person requesting a Reasonable Accommodation: _____

Address: _____

Phone: _____

Section 504 of the Rehabilitation Act and the Fair Housing Amendments Act defines a "disability" as a physical or mental impairment which substantially limits one or more of a person's major life activities, a record of having such impairment, or being regarded as having such an impairment.

1. Based on the above definition I consider myself to be an individual with a disability.

Yes No

2. Because of my disability, I am requesting a reasonable accommodation to have an equal opportunity to participate in or benefit from Garfield County Housing Authority (GCHA).

Yes No

Because of my disability, I am requesting the following accommodation to have an equal opportunity to participate in, or benefit from, GCHA's housing program:

3. _____

4. Because of my disability, the above accommodation is necessary because: _____

5. Verification Information: Please provide GCHA with the contact information of a **knowledgeable professional** who can verify the disability and the need for the requested reasonable accommodation:

Name of Professional/Care Provider: _____

Title: _____

Address: _____

Phone: (_____) _____

Authorization to release information: I authorized the individual/care provider listed above to disclose relevant information to Garfield County Housing Authority verifying that I have a disability and need the accommodation I have requested. I understand that the information that GCHA obtains will be kept confidential and used solely to determine if an accomodation should be provided

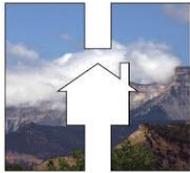
Signature of Participant: _____ Date: _____

Name of Participant: _____



Warning: Section 1001 of Title 18 of the United States Code, states that a person who knowingly and willingly makes false or fraudulent statements to any department or agency of the United States is guilty of a felony. This institution is an equal opportunity provider and employer.





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2/2019

Verification of Knowledgeable Professional/Care Provider

Participant's Name: _____ Last 4 of SSN: _____

Date: _____

The individual listed above has identified him/herself as being a person with a disability and has requested from Garfield County Housing Authority (GCHA) an accommodation to have an equal opportunity to benefit from its housing programs. An accommodation must be reasonable and there must be an identifiable relationship between the requested accommodation the applicant or participant's disability. You have been authorized to release information to us regarding the need for an accommodation. (Please see the Authorization to Release Information accompanying this form).

Section 504 of the Rehabilitation Act and the Fair Housing Amendments Act define a disability as a physical or mental impairment which substantially limits one or more of a person's major life activities, a record of having such impairments, or being regarded as having such an impairment.

- Does this individual have a disability, as defined above Yes () No ()
- Describe how the requested reasonable accommodation on the attached Request for Reasonable Accommodation form is necessary to afford this individual the opportunity to access housing, maintain housing, or for full use and enjoyment of the housing:

- Is the accommodation requested directly related to the participant's disability? Yes () No ()

Name and address of provider completing form:

Printed Name: _____

Title: _____

Address: _____

Telephone Number: _____

Fax Number: _____

Signature: _____

Date: _____

Note: Please attach additional pages if necessary to provide any additional information that may assist us in reaching a decision. However, please do not include any medical diagnosis on this form!

2/2019



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