Englewood Housing Authority

EQUAL HOUSING OPPORTUNITY

Let's Clear the Air

June 4, 2014

Re: Voluntary Compliance Agreement dated May 7, 2014

Dear Prospective Applicant:

Pursuant to the terms of the Voluntary Compliance Agreement between HUD and the Englewood Housing Authority, you are receiving this letter because you have been identified as a non-elderly, applicant with a disability on one of Englewood Housing Authority's waiting lists and are potentially eligible for a one bedroom apartment at Orchard Place Apartments located at 3425 South Sherman Street, Englewood CO 80113. This letter **does not** indicate that there is an apartment available immediately.

This letter is to inform you that you have equal priority for one bedroom smoke free housing at Orchard Place. If you are not currently on the Orchard Place waiting list but are on the waiting list for alternate housing, (for example a duplex unit), you may be placed on the Orchard Place waiting list based on the date and time of your initial waiting list application. If you are not already on the Orchard Place waiting list and choose to be added to the Orchard Place waiting list, it will not affect your placement on any other Englewood Housing Authority waiting list.

If you are on the Orchard Place waiting list and wish to remain on the list, no action is necessary. If you are not on the Orchard Place waiting list and wish to be placed on the Orchard Place waiting list, you must respond by marking the appropriate line on page two and returning it to EHA in the enclosed postage paid envelope **within 10 business days of the date of this letter.** The response must be returned to:

Englewood Housing Authority
3460 South Sherman Street #101
Englewood CO 80113
Attention: Renee Tullius

You have the right to request a reasonable accommodation. A reasonable accommodation is a change or modification to a policy, program, service, or workplace that will allow a qualified person with a disability to participate fully. For example, a tenant who has difficulty walking may request an accessible parking spot close to a building entrance as a reasonable accommodation. If you require an accessible unit or a reasonable accommodation please indicate this below.

If you require a reasonable accommodation, please return the attached forms with your response indicating what accommodation you require.

Please contact Renee Tullius at 303.761.6200 x222 if you have a question.

Sincerely,

/s/

Renee Tullius
Executive Director

If applicable, please mark your response below and return this page to EHA in the enclosed postage paid envelope.

*I am not on the Orchard Place waiting list. Please add my name to the Orchard Place waiting list based on the date and time of my initial waiting list application.*_____

*I wish to request a reasonable accommodation. I am returning the form provided.*_____

I require an accessible unit. _____

Name *Date*

FORM #1

REQUEST FOR ACCOMMODATION

DO NOT RETYPE OR ALTER THIS FORM IN ANY WAY

NAME: _____ **TELEPHONE NO.:** _____

ADDRESS: _____

CITY, STATE, ZIP CODE: _____

PROGRAM: PUBLIC HOUSING_____ **SECTION 8:**_____ **ARE YOU AN APPLICANT?** ☐ **YES** ☐**NO**

1. The following member of my household has a disability, *i.e.*, a physical or mental impairment that substantially limits one or more life activities.

   Name: _____
   Relationship or association with you: _____

2. I authorize EHA to verify that I have a disability and need the accommodation I have requested. In order to verify this information, EHA may contact the following health care provider or licensed service agency:
   REQUIRED INFORMATION:

   Name: _____
   Title of Health Care Provider: _____
   Agency, Facility or Institution (if any):_____
   Address: _____
   City, State, Zip Code: _____
   Telephone: _____ Fax: (required) _____

3. I authorize the Health Care Provider to release the medical information requested in Form #2 to the Housing Authority of the City Englewood ("EHA"), and any other information necessary to assess the Applicant's request for an accommodation(s).

   Signature: _____ Date: _____

4. As a result of this disability, I am requesting the following accommodation: (Please check one or more boxes below):

   ☐ A change in my apartment or the public or commons areas of the housing development. Please explain why the requested change is necessary and specifically state the change you are requesting. _____

   _____

   _____

   ☐ An exception to a rule, policy, practice or service. (You may request a change that you believe will allow you to comply with the terms of the lease or voucher, but everyone is required to comply with the essential terms of their lease or the voucher program.) Please explain why the exception you are requesting is necessary, and specifically identify the exception you want EHA to make._____

   _____

   _____

   _____

   _____

   _____

   _____

☐ Other (for example, a change in the way EHA communicates with you). Please specify:

_____

_____

_____

5. This accommodation is necessary so that I can: (Please state how the accommodation will provide you with an equal opportunity to participate in, or benefit from, EHA housing programs.)

_____

_____

_____

NOTE: EHA REQUESTS THE INFORMATION ABOVE IN CASE ADDITIONAL INFORMATION IS NECESSARY TO CONSIDER YOUR REQUEST. PLEASE PROVIDE THE REQUESTED INFORMATION ONLY FOR THE INDIVIDUAL WHO COMPLETED FORM #2 – HEALTH CARE PROVIDER VERIFICATION FORM YOU ARE SUBMITTING WITH THIS REQUEST. YOU MUST HAVE YOUR HEALTH CARE PROVIDER COMPLETE FORM #2 – HEALTH CARE VERIFICATION FORM ATTACHED TO THIS REQUEST.

Complete the following, if applicable.
I authorize EHA to contact the following individual who assisted me in the completion of this form:

Name: _____

Address: _____

City, State, Zip Code: _____

Telephone: _____

I understand that the information obtained by EHA will be kept completely confidential, to the extent permitted by law, and used solely to make a determination regarding my accommodation request.

Signed: _____ Date: _____
(Head of Household or Authorized Representative)

Signed: _____ Date: _____
(Individual with the Disability, if Over 18)

This form and the completed Health Care Provider Verification form must be submitted to the Administrative Manager, Englewood Housing Authority, 3460 South Sherman Street, Suite 101, Englewood, Colorado, 80113.

If you have any questions regarding this form, please contact an EHA employee in the program from which you obtained this form (e.g., Section 8 or Public Housing).

INFORMATION SHEET FOR COMPLETING THE HEALTH CARE PROVIDER'S VERIFICATION OF NEED FOR AN ACCOMMODATION IN HOUSING BECAUSE OF A DISABILITY FORM

The Housing Authority of the City of Englewood ("EHA") is a federally funded program. Therefore, Section 504 of the Rehabilitation Act of 1973 ("Section 504") requires EHA to provide reasonable accommodations to qualified program applicants or participants of the Section 8 and public housing programs (herein referred to as "Applicant"). EHA may verify that the requested accommodation is necessary to give the Applicant an equal opportunity to participate in, or benefit from, EHA housing programs. EHA has implemented a process to review requests for accommodations submitted by the Applicant. The attached form provides EHA with verification of the Applicant's disability, and the necessity of the requested accommodation. EHA may also verify the Applicant's disability only to the extent necessary to ensure that the Applicant has a need for the requested accommodation. Therefore, **DO NOT** provide medical records, or specify the Applicant's disability, or provide any specific details about the nature of the disability in your response.

WHAT QUALIFIES AS A DISABILITY?

A person with a disability is one who:

1. Currently has a physical or mental impairment that substantially limits one or more major life activities; or
2. Has a record of such an impairment; or
3. Is regarded as having such impairment.

This definition may differ from the medical definition of "disability." However, this is how "disability" is defined by Section 504, and is the definition you **must** use in evaluating and certifying whether the Applicant meets the definition of a person with a "disability." You **must** strictly interpret and apply this legal definition. The key words in this definition are, "substantially limits" one or more "major life activities."

The United States Supreme Court has ruled that a person is "substantially limited" in performing a major life activity only if the impairment prevents or severely restricts the Applicant from engaging in certain major life activities. A major life activity is "substantially limited" if the Applicant is unable to perform a particular life activity that the average person in the general population can perform, or is significantly restricted in "the condition, manner, or duration" under which he/she can perform a particular life activity as compared to an average person in the general population. If the impairment interferes only in a minor way with the performance of a stated major life activity, the Applicant may not, in some circumstances, be considered a person with a disability if the impairment is not "substantially limiting." Based on this definition, it is clear that any number of impairments may not fall within the legal definition of "disability," in which case the Applicant is not qualified for an accommodation. Physical or mental impairment does not include simple physical characteristics such as blue eyes or black hair, nor does it include environmental, cultural, economic or other disadvantages such as having a prison record. Your role, as the health care provider, is to provide EHA with your professional opinion regarding whether the Applicant's current impairment meets the legal definition of a disability.

It is not possible to include a list of all the specific conditions or diseases that would or would not constitute a physical or mental impairment because of the difficulty of ensuring the comprehensiveness of such a list; however, below are some qualifying mental and physical impairments and a list of some of the exclusions under the law.

a) *Physical or mental impairment* includes:(1) Any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: Neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive; digestive; genito-urinary; hemic and lymphatic; skin; and endocrine; or(2) Any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities. The term *physical or mental impairment* includes, but is not limited to, such diseases and conditions as orthopedic, visual, speech and hearing impairments, cerebral palsy, autism, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, Human Immunodeficiency Virus infection, mental retardation, emotional illness, drug addiction (other than addiction caused by current, illegal use of a controlled substance) and alcoholism.

However, a diagnosis of impairment alone is not determinative of whether an Applicant is disabled. As explained below, the impairment must substantially limit one or more of the Applicant's major life activities.

WHAT QUALIFIES AS A "MAJOR LIFE ACTIVITY"?

"Major life activity" refers to those activities that are of central importance to most people's daily lives. The tasks in question must be central to daily life. A qualified person with a disability is an individual with an impairment that substantially impacts one or more life functions.

WHAT IS A REASONABLE ACCOMMODATION?

A reasonable accommodation is a modification to an Applicant's unit, common or public areas of the

facility, or a change in rules, policies, practices or services that will allow a person with a disability to have an equal opportunity to participate in, or benefit from, EHA housing programs.

An accommodation is not reasonable simply because the Applicant is a qualified person with a disability. The accommodation must be reasonable **and** there must be an identifiable relationship, or nexus, between the requested accommodation and the Applicant's disability. Therefore, you must provide your professional opinion about why the requested accommodation is necessary in order for the Applicant to have an equal opportunity to participate in, or benefit from, EHA housing programs, because of the Applicant's disability.

On the attached form you must:

1. specifically identify the major life activities that are affected by the Applicant's disability;
2. describe how these major life activities are substantially affected by the Applicant's disability;
3. explain how the accommodation is directly related to the Applicant's disability; and

PLEASE RETURN FORM #2 – HEALTH CARE PROVIDER VERIFICATION FORM, TO THE APPLICANT. THEY MUST SUBMIT THIS FORM, WITH THEIR REQUEST FOR ACCOMMODATION TO EHA. IF ADDITIONAL INFORMATION IS REQUIRED, EHA WILL CONTACT YOU DIRECTLY. EHA WILL VERIFY, BY FAX, THAT YOU HAVE COMPLETED FORM #2 – HEALTH CARE PROVIDER'S VERIFICATION. PLEASE NOTE THAT EHA CANNOT BEGIN PROCESSING THE APPLICANT'S REQUEST FOR REASONABLE ACCOMMODATION UNTIL EHA RECEIVES YOUR FAX VERIFICATION.

FORM #2

HEALTH CARE PROVIDER'S VERIFICATION OF NEED FOR AN ACCOMMODATION IN HOUSING BECAUSE OF A DISABILITY

DO NOT RETYPE OR ALTER THIS FORM IN ANY WAY

SECTION A

Applicant's Name: _____

Address: _____
(Street Address, City, State, Zip Code)
Requested Accommodation: _____

Applicant must fill in all blank lines above in this Section A, and sign on the line above and date. Then take this form to your Health Care Provider so that he/she can complete Section B below. NOTE: IF BOTH SECTIONS A AND B HAVE NOT BEEN COMPLETED, YOUR REQUESTED ACCOMMODATION MAY BE DENIED.

SECTION B

Health Care Provider must fill in all appropriate blanks below in this Section B. DO NOT ATTACH ANY MEDICAL RECORDS OR OTHER DOCUMENTATION REGARDING THE INDIVIDUAL'S DISABILITY. You must address these issues in your answers to the questions below. EHA cannot and will not interpret documentation regarding an individual's disability to determine if their disability requires the requested accommodation. As the Health Care Provider it is your responsibility to provide the necessary information regarding the individual's disability and how that disability is related to their Request for Accommodation. Before you complete this form, please read the attached information sheet so that you clearly understand what an accommodation is and how the law defines "disabled." If a question is not applicable write "N/A" next to the question.

_____
Health Care Provider's Name (please print clearly)

_____
Street Address

_____
City, State and Zip Code

_____
Telephone Number

_____
Fax Number

The person named above is an Applicant for an accommodation because of disability, and is requesting that EHA provide them with the accommodation stated in Section A above.

After you have completed this form, please return it to the Applicant, so they may submit the necessary forms to EHA for their request to be considered.

1. In my opinion, the Applicant has a disability as defined below. Please check any paragraph below that applies. (**If none of these apply, please go to Question 2**)

   [ ] A. A physical or mental impairment that substantially limits one or more major life functions.

2. [ ] In my opinion this individual does not qualify as a person with a disability as discussed above. **Please go to the end of this form, read the certification and sign the bottom of this form.**

3. Specifically identify the "major life activities" that are affected by the Applicant's physical or mental impairment.

   _____

   _____

4. Are you aware of any alternatives that would provide a similar accommodation for the Applicant's disability?

   [ ] **YES** [ ] **NO**

   If yes, please explain in detail: _____

   _____

   _____

5. In my opinion, the Applicant's disability requires that one or more of the following categories of accommodations be made in order for the Applicant to have an equal opportunity to participate in, or benefit from, EHA housing programs: (a) a fully accessible apartment or other physical modifications to the apartment or public/common areas, including assistive technology, (b) changes in EHA's rules, policies, practices, or services of the housing development, or EHA, as applied to Applicant, or (c) assistance with communications with EHA.

   [ ] YES (Please respond to each of the following questions.)
   [ ] NO (Please go to the end of this form, read the certification and sign the bottom of this form.)

   IF APPLICANT IS REQUESTING TO RENT A SECTION 8 UNIT FROM A RELATIVE, PLEASE SKIP SUBSECTIONS A THROUGH D BELOW AND GO TO QUESTION 8.

   IF APPLICANT REQUIRES AN EXTRA BEDROOM FOR MEDICAL EQUIPMENT, PLEASE SKIP SUBSECTIONS A THROUGH D BELOW AND GO TO QUESTION 9.

   IF APPLICANT REQUIRES AN ASSISTANCE ANIMAL PLEASE SKIP SUBSECTIONS A THROUGH D BELOW AND GO TO QUESTION 10.

   IF APPLICANT REQUIRES AN EXTRA BEDROOM FOR A LIVE-IN-AIDE PLEASE SKIP SUBSECTIONS A THROUGH D BELOW AND GO TO QUESTION 11.

   OTHERWISE, ANSWER THE FOLLOWING QUESTIONS:

   A. Specifically identify the accommodation(s) required.

   _____

   _____

   B. Why does the Applicant need the requested accommodations?

   _____

   _____

   _

   C. How is this accommodation(s) directly related to the Applicant's disability?

   _____

D. How will the requested accommodation(s) enable the Applicant to have an equal opportunity to participate in, or benefit from, EHA housing programs?

6. If Applicant is requesting to rent a Section 8 unit from a relative, please respond to the following questions: **(NOTE: YOU MUST TIE THE NECESSITY OF RENTING THE SPECIFIC UNIT IN QUESTION TO THE INDIVIDUAL'S DISABILITY AND EXPLAIN WHY THEY ARE NOT ABLE TO FIND THE SAME ACCOMMODATION IN A UNIT THAT IS NOT OWNED BY A RELATIVE.)**

Renting from a Relative

A. Does the unit the Applicant is requesting to rent have any special features required because of the Applicant's disability?
[ ] YES
[ ] NO (Please go to the end of this form, read the certification and sign the bottom of this form.)

B. What are the special features of the unit? Provide a detailed description of each feature.

C. Identify the relationship, or nexus, between the special features of the unit and the Applicant's disability.

D. List all modifications made to the unit specifically designed to aid the Applicant.

9. If the Applicant is requesting an extra bedroom to store medical and/or exercise equipment, please respond to the following questions: **(NOTE: EXERCISE EQUIPMENT MUST BE PRESCRIBED FOR THE APPLICANT'S DISABILITY AND CANNOT SIMPLY BE ANY EXERCISE EQUIPMENT THAT WOULD BE BENEFICIAL TO ANYONE'S GENERAL HEALTH.**

A. Have you prescribed the medical and/or exercise equipment for the Applicant??
[ ] **YES**
[ ] **NO**

B. Does the Applicant need medical equipment or exercise equipment that requires storage in a separate location, other than the living room, bathroom, kitchen, or Applicant's bedroom(s)?
[ ] **YES**
[ ] **NO**

C. List all medical equipment and/or exercise equipment the Applicant has at home and the approximate size of the equipment.

D. Why must the Applicant store this equipment in a separate bedroom instead of another room of the unit?

E. Where does the Applicant use the medical equipment or exercise equipment? How often is it used?

F. Identify the relationship, or nexus, between the Applicant's request for an additional bedroom, the need for the medical equipment or exercise equipment, and the Applicant's disability.

_____

_____

7. Federal regulations require EHA to allow, as a reasonable accommodation, a qualified person with a disability to own and keep an "assistance animal" (also referred to as a service animal or companion animal), on EHA's premises. An assistance animal is an animal that works, provides assistance, or performs tasks for the benefit of a person with a disability; or animals that provide emotional support that alleviate one or more identified symptoms or effects of a person's disability. If the Applicant is requesting that they be allowed to keep an assistance animal, please answer the following questions: A. Does the Applicant require an assistance animal as defined above?

[ ] **YES**
[ ] **NO**

B. Identify the relationship, or nexus, between the Applicant's request for an assistance animal and the Applicant's disability.

_____

_____

_____

_____

_____

_____

_____

_____

_____

8. Federal regulations require EHA to allow, as a reasonable accommodation, a qualified person with a disability to have a Live-in-Aide (also referred to as a Personal Care Provider, Caregiver etc.) and approve one (1) additional bedroom for the Live-In-Aide. A Live-In-Aide is a person who resides with one or more elderly persons or near-elderly persons, or persons with disabilities, and who: (1) is determined to be essential to the care and well-being of the person(s); (2) is not obligated for the support of the person(s); and (3) would not be living in the unit except to provide the necessary supportive services.

A. Does the Applicant have a disability that requires a Live-in Aide?

[ ] YES
[ ] NO
If yes, please explain in detail:

_____

_____

B. The Live-In-Aide will provide health and/or supportive care services as follows:

_____

_____

_____

C. The health and/or supportive care services are needed:

[ ] **FULLTIME**
[ ] **PART-TIME**

If Part-time, what hours of the day? From_____ to _____

D. How many nights a week are the health and/or supportive services needed?

I HEREBY CERTIFY THAT I HAVE READ THE INFORMATION SHEET FOR COMPLETING "FORM #2 – HEALTH CARE PROVIDER'S VERIFICATION OF NEED FOR AN ACCOMMODATION IN HOUSING BECAUSE OF A DISABILITY" AND I UNDERSTAND ITS CONTENTS. I FURTHER CERTIFY THAT ALL INFORMATION I PROVIDED IN THIS FORM IS ACCURATE, COMPLETE, AND CURRENT.

Signature of Health Care Provider (*please sign with blue ink*) Date

Thank you.
If you have any questions, please contact the Administrative Manager,
at (303) 761-6200 extension 225;
3460 S Sherman Street, Suite 101
Englewood, Colorado 80113-2664