HOUSING AUTHORITY OF THE CITY OF LOS ANGELES
REASONABLE ACCOMMODATION QUESTIONNAIRE

A person with a disability(ies) may request a change, exception or adjustment to HACLA's rules, policies, practices, procedures or modifications to its housing units or common areas as a reasonable accommodation. Requesting an accommodation does not affect participation in the program. **This form is to be completed and returned to the HACLA as part of the application and annual review process but can be requested and submitted at any time as needed.**
Contact your HACLA worker if assistance is needed in completing this form.

Head of Household Name: ______________________________________ Reg # / Client # ________

Address: ____ Phone # ________________

Other preferred contact information: ____

Please check the appropriate box, provide the information as necessary, sign the bottom, and submit to the HACLA.

1. Does anyone in your household need a reasonable accommodation?

   ☐ No - If **No**, complete number 3 below

   ☐ Yes - If **Yes**, complete numbers 1a, 1b, 1c, 2, and 3 below

   1a. Print the name of the family member requiring the accommodation _____________________

   1b. Describe the accommodation needed ____

   ____

   ____

   1c. Is this request to rescind a negative action taken by HACLA because the family did not comply with program requirements and the reason for not complying was due to a household member's disability? ☐ No ☐ Yes

   If **Yes**, how did the disability prevent compliance with the rules and requirements of the program? *(Include any applicable dates)* ______________________________________

   ____

   ____

   ____

2. Person who can verify the disability and the disability-related need for the accommodation, such as (but not limited to): a licensed physician, physical therapist, psychiatrist, social worker, caseworker, or counselor).

   Name: ____

   Agency (if applicable): ____

   Address: ____

   Phone number: (____) ___________________ Fax number: (____) _____________________

   E-mail (if known): ____

3. Signature: I certify the above information is correct:

____ ________________

Signature of Head of Household or Cohead Date

Please submit the completed form to the HACLA

For HACLA use only	
Received by: ________________________ Date _________	Cal/Manager Code __________
	Unit No.____________
	Reg./Client No.____________
Notes:	Review Month ____________

S504-02 (1/24/2013)