



**Boston Housing Authority**  
 \_\_\_\_\_ Dpt.  
 52 Chauncy Street  
 Boston, Massachusetts 02111-02375

617-988-\_\_\_\_\_  
 TDD 1-800-545-1833 Ext. 420  
 www.bostonhousing.org

**This is an important document. If you require interpretation, please call the telephone number below or come to our offices.**

Este es un documento importante. Si necesita interpretación, por favor llame al número de teléfono que aparece abajo o visite nuestras oficinas

這是一份非常重要的文件。如果您需要翻譯服務，請撥下面的電話或前往我們的辦公室

Isto é um documento importante. Se exige interpretação, por favor chama o número de telefone embaixo ou vem a nossos escritórios.

Это важный документ. Если Вам требуется перевод, пожалуйста позвоните нам (телефонный номер ниже). Или придите в наш офис.

Đây là một tài liệu quan trọng. Nếu quý vị cần phiên dịch, vui lòng hãy gọi cho số điện thoại bên dưới hoặc đến các văn phòng của chúng tôi.

**នេះ គឺជាឯកសារសំខាន់មួយ។ ក្នុងករណីលោកអ្នក ចាំបាច់ត្រូវចង់បានការបកប្រែ សូមទូរស័ព្ទលេខខាងក្រោមនេះមកកាន់ ឬ អញ្ជើញមកទាក់ទងដោយផ្ទាល់នៅការិយាល័យយើងខ្ញុំ។**

**Sa a se yon dokiman enpòtan. Si ou bezwen entèpretasyon, tanpri rele nimewo telefòn ki anba la a oswa vini nan biwo nou.**

**Tani waa dhokomenta muhiim ah. Haddii aad rabto tarjumad, fadlan wac lambarka hoos ku qoran ama imow xafiisyadayada.**

هذه وثيقة مهمة، وإذا كنت في حاجة إلى ترجمة فورية، يرجى الاتصال على رقم الهاتف المذكور أدناه أو أن تتفضل بالمجيء إلى مكتبنا.

این یک سند بسیار مهم است. اگر به ترجمه آن نیاز دارید، لطفاً با شماره تلفن زیر تماس بگیرید یا به دفتر ما مراجعه کنید.

**Telephone No. : 617-988-4315**

(THIS FORM IS AVAILABLE IN ALTERNATIVE FORMAT UPON REQUEST)

**REQUEST FOR REASONABLE ACCOMMODATION**

This form is to be completed by the Head of household on behalf of the household member needing the accommodation and it must be signed by both the Head and the household member if 18 years of age or older.

Name of Person Whom Needs the Accommodation: \_\_\_\_\_

Name of Head of Household: \_\_\_\_\_

Address: \_\_\_\_\_ Unit # \_\_\_\_\_

Daytime Phone#: \_\_\_\_\_

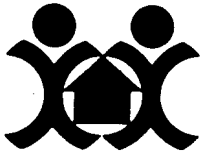
1. I am a person with a disability as defined by one or more of the following: **A physical or mental impairment that substantially limits one or more life activities; or a record of having such an impairment; or is regarded as having such an impairment.**

\*\*If I am not the person with a disability, the following member of my household has a disability as defined above:

Name: \_\_\_\_\_

Relationship to you (e.g. child, parent): \_\_\_\_\_

**Please be sure you have filled out both pages of this form.**  
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2. As a result of this disability, I am requesting the following reasonable accommodation for my household: (Please check one or more boxes below.)

( ) A change in my apartment or other part of the housing development. Please specify:  
 \_\_\_\_\_  
 \_\_\_\_\_

( ) A change in the following rule, policy or procedure. (Note that a change in how to meet the terms of the lease may be requested, but the terms of the lease must be met.) Please specify:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

( ) Other (for example, a change in the way the BHA communicates with you). Please specify: \_\_\_\_\_

3. This request for reasonable accommodation is necessary so that I can:

\_\_\_\_\_  
 \_\_\_\_\_

4. To get to my appointments, I rely most on (please circle one):

**my car      the bus      the T      the RIDE      walking**

**a friend or family member drives      other (please specify) \_\_\_\_\_**

5. I authorize the Boston Housing Authority to verify that I have or someone in my household has a disability and we have the need for the reasonable accommodation I have requested. In order to verify this information the BHA may contact the following physician, psychiatrist, licensed psychologist, licensed nurse practitioner, licensed social worker, rehabilitation professional, or non-medical service agency whose function is to provide services to the disabled, or other expert in the field of \_\_\_\_\_. (Note: You may present verification directly to the BHA.)

**Name of Provider:** \_\_\_\_\_

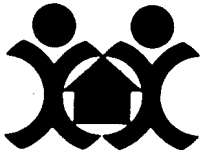
**Title of professional or expert:** \_\_\_\_\_

**Agency/Clinic/Facility:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Telephone:** \_\_\_\_\_

**Fax:** \_\_\_\_\_



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I understand that the information obtained by the BHA will be kept completely confidential and used solely to make a determination on my reasonable accommodation request.

Please return this form as promptly as possible so that the BHA may make a determination on this request.

**Signed:** \_\_\_\_\_  
[\*\*Head of household or authorized guardian]

**Signed:** \_\_\_\_\_  
[\*\*Adult household member needing the accommodation, 18 years of age or older]

**Date:** \_\_\_\_\_

**Witness & Relationship:** \_\_\_\_\_ **Date:** \_\_\_\_\_

\*\*If on behalf of a minor child, please indicate whether you are the parent or guardian. Where the individual with the disability is over 18 and is not the head of household, s/he must sign the authorization for verification.