NOHA
northwest oregon housing authority

location
147 s. main avenue
warrenton or 97146

mailing
po box 1149
warrenton or 97146

office 503-861-0119
fax 503-861-0220

toll free 1-888-887-4990
tdd 1-800-927-9275

www.nwoha.org

REASONABLE ACCOMMODATION

The Northwest Oregon Housing Authority (NOHA) is committed to providing reasonable accommodation to person with disabilities to help ensure an otherwise eligible person receives an equal opportunity to participate in and benefit from its housing programs. Upon request, a reasonable accommodation to change NOHA policies and procedures will be considered.

Reasonable accommodation requests may be submitted either in writing or verbally at any time to NOHA; this forms is also available on our website: www.nwoha.org.

Instructions on submitting a request for a Reasonable Accommodation:

1. This form has three (3) pages, including this cover page.
2. The second page includes a series of questions that must be answered by the Head of Household, or the person who is submitting the request on behalf of the family member with a disability. All requests will be verified by a third party knowledgeable professional. The final page is an Authorization for the Release of Information.
3. You must complete both forms on pages 2 and 3, sign the "Authorization for Disclosure of Use of Health Information" form and submit the documents to NOHA.
4. If the disabled family member is 18 years of age or older, he or she AND the Head of Household must sign the "Authorization for Disclosure of Use of Health Information" form. The Head of Household or legal guardian must sign on behalf of a disabled minor requesting the accommodation.
5. If you need assistance in completing any of the documents in this packet or require translation services, contact your housing specialist at NOHA.
6. For your convenience, you may submit the completed forms to NOHA by fax to 503-861-0220 or by mail to NOHA, PO Box 1149; Warrenton, OR 97146, by dropping off with front desk personnel during regular business hours, or by dropping off in the drop box located outside the front door to NOHA at 147 S Main Ave; Warrenton, OR 97146.

When ALL required documentation has been received (this includes verifications from the third-party professional) NOHA will respond to your request for a reasonable accommodation.

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Reasonable Accommodation Request Questionnaire

Head of Household Name: _____

Address: _____

City: _____ Zip Code: _____

Contact Phone Number: _____

Email Address: _____

1. Name of person with disability: _____
2. Is this person a minor (age 17 or younger)? ☐ Yes ☐ No
3. Without providing any details of the disability itself, indicate the type of accommodation being requested as a medical necessity: (Please DO NOT submit medical records)

   ☐ Separate sleeping room due to medically related reasons
   ☐ Additional room for medical equipment
   ☐ Additional bedroom for 24-hour personal care attendant (live-in care provider)
   ☐ Rent a unit from a relative who is NOT and will NOT reside in the unit
   ☐ Other: _____

   _____

4. The accommodation is needed because: _____

   _____

5. Name of doctor, health care professional, mental health professional, case manager, counselor, or another reliable professional third party who is in a position to know about the individual's disability and need for an accommodation.

   Print Name of Provider: _____

   Title (if applicable): _____

   Address: _____

   Phone #: _____ Fax #: _____

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AUTHORIZATION FOR DISCLOSURE OR USE OF HEALTH INFORMATION

Head of Household: Tenant ID:

Completion of this document authorizes the disclosure and/or use of individually identifiable health information as set forth below. Failure to provide all information requested may invalidate this Authorization.

Patient/Client Name: _____ DOB: _____

I authorize the exchange of health information (as specified below) deemed necessary to complete and verify my application for participation and/or to maintain my continued assistance under the Section 8 Housing Choice Voucher program between the Northwest Oregon Housing Authority (NOHA) and the following person/organization:

Name of Person/Agency: _____

Address: _____

This authorization applies to the following information (select only one of the following):

☐ All health information necessary to evaluate disability related need for a reasonable accommodation

☐ Only the type of health information related to: _____

_____

This authorization expires 15 months from the date it was signed, unless consent is withdrawn in writing.

My rights: I may refuse to sign this authorization. I may inspect or obtain a copy of the health information that I am being asked to disclose. I have a right to receive a copy of this authorization. I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to: NOHA; PO Box 1149; Warrenton, OR 97146 or 147 S Main Ave; Warrenton, OR 97146. My revocation will be effective after 48 business hours from receipt, but will not be effective to the extent that the requestor has acted in reliance upon this authorization.

I acknowledge and agree a photocopy of this authorization shall be as valid as the original and may be used for the above stated purpose.

Head of Household: _____ _____ _____
Print Name Signature Date

Name of Patient: _____ _____ _____
Print Name Signature Date

If you are signing on behalf of the patient/client, state your legal relationship: _____

EQUAL HOUSING OPPORTUNITY