HARRISONBURG
REDEVELOPMENT AND
HOUSING AUTHORITY
P.O. BOX 1071 ✦ HARRISONBURG, VA 22803
Phone/VTDD 540-434-7386 ✦ Fax 540-432-1113

REASONABLE ACCOMMODATION REQUEST FOR EXTRA ROOM

COMPLETED BY CLIENT

Person Needing Accommodation		Head of Household (if different)
Unit & Street Address	City, State, Zip	Phone

1. My household currently lives in a _____ bedroom unit. If an extra bedroom subsidy is approved, I will:
   ☐ Keep my current unit where I am now over-housed ☐ Move to a larger unit
2. I am elderly, near elderly, and/or disabled: ☐ Yes ☐ No
3. Due to my condition, an extra room is necessary to afford me equal use & enjoyment of my housing: ☐ yes ☐ no
4. The way an extra room will help me use and enjoy housing is (*you do not have to disclose the disability*):
   If the extra room is for medical equipment, please provide dimensions and/or functional requirements.
5. Describe why the current voucher and/or unit (including living room) is inadequate:
6. I authorize the following care provider to verify my condition or disability-related need for a live-in aide

Provider Name	Agency/Facility	
Title/Profession	Fax	Phone
Address		City, State, Zip

CERTIFICATION

I certify that the information provided on my request for an extra bedroom is true, correct and complete. I understand that for HRHA to process my request, a care provider must verify my disability and need for accommodation. I understand that if my request is approved, HRHA can re-verify my need for accommodation in the future, and may also verify that the requested room is being used for the disability-related purpose.

RELEASE / AUTHORIZATION

I authorize HRHA to contact the provider named above to verify my disability and/or medical need for an extra bedroom. I understand that this release is limited to information required to verify my request and that information obtained by HRHA will be kept confidential and used solely to make a determination on this request. I understand that I may submit supporting documentation directly to HRHA, and that HRHA will not seek details on the nature or severity of my disability.

Name of Person Requiring Accommodation	Signature	Date

☐ Check here if parent/guardian signing on behalf of a minor child.

WARNING: Title 18, Section 1001 of U.S. Code states that a person is guilty of a felony for knowingly and willingly making a false or fraudulent statement to any department or agency of the United States Government.

I understand that this authorization is voluntary; I can withdraw permission at any time. I understand that HRHA is not a healthcare provider, and released information will be kept confidential but is not subject to HIPAA. I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to the releasing agency. Written revocation will be effective upon receipt, but will not apply to information already released in response to authorization. I understand that once my healthcare provider discloses my information to HRHA, they are no longer responsible for its privacy. I understand that I have a right to receive a copy of this authorization for my records. Copies of this release should be treated the same as an original.