HOUSING AUTHORITY
of the City of Beaumont, Texas

HOUSING CHOICE VOUCHER (SECTION 8)
REQUEST FOR REASONABLE ACCOMMODATION

Interpreter Services

You have the right to an interpreter at no cost to you. Please point to your language. An interpreter will be called. Please wait.

Albanian
Shqip
Keni të drejtën për përkthyes falas gjatë vizitës mjeksore. Ju lutem tregoni me gisht gjuhën që flisni. Ju lutem prisni, do t'ju gjejmë një përkthyes për viziten mjekësore.

Amharic
አማርኛ
ያለምንም ወጪ አስተርጓሚ የማግኘት መብት አለዎት ። የሚናገሩትን የሚረዱበትን ቋንቋ በመጠቆም ያመልክቱ ። አስተርጓሚ እስኪጠራ ድረስ እባክዎ ይታገሱ ።

Arabic
عربي
يحق لك الحصول على خدمات ترجمة فورية دون أي مقابل.
يُرجى منك أن تُشيربإصبعك الى لغتك كي تستدعي المترجم المعني.
يُرجى منك الإنتظار لحين استدعاء المترجم.

Armenian
Հայերեն
[illegible]

Bengali
বাংলা
আপনার অধিকার রয়েছে বিনামূল্যে একজন দোভাষী পাওয়ার। অনুগ্রহ করে আপনার ভাষা কোনটি তা দেখিয়ে দিন। একজন দোভাষীকে ডাকা হবে। অনুগ্রহ করে অপেক্ষা করুন।

Cape Verdean Creole
Criolu di Cabu Verdi
Nhôs tem direito a um intérprete gratuíto di nhôs língua. Mostra qual qui nhôs língua pa nô podi tchoma intérprete. Nhôs aguarda um momento, por favor.

Haitian Creole
Kreyòl Ayisyen
Ou gen dwa a yon entèprèt gratis. Tanpri montre nou lang pa w la. N ap rélé yon entèprèt pou ou. Tanpri ret tann.

Hebrew
עברית
יש לך זכות להשתמש בשרותיו של מתורגמן ללא תשלום. אנא הצבע על השפה שלך. מיד ניצור קשר עם מתורגמן. אנא המתן.

Hindi
हिन्दी
आपको नि:शुल्क दुभाषिया (अनुवादक) प्राप्त करने का अधिकार है। कृपया अपनी भाषा की ओर इशारा करें। एक दुभाषिया (अनुवादक) को बुलाया जाएगा। कृपया प्रतिक्षा करें।

Hmong
Hmoob
Koj muaj cai txais kev pab txhais lus dawb tsis them nyiaj. [illegible] is nov. Mam hu tus txhais lus.

Italian
Italiano
Avete diritto ad un interprete. Il servizio è gratuito. Indicate la vostra lingua e attendete; un interprete sarà chiamato al più presto.

Japanese
日本語
通訳を無料でご利用になれます。該当する言語を指示して下さい。通訳を手配いたしますのでお待ち下さい。

Khmer

Russian
Русский
Вы имеете право на услуги бесплатного переводчика. Назовите, пожалуйста, свой язык. Медицинский переводчик будет вызван. Пожалуйста, подождите.

Serbo-Croation
Srpsko-Hrvatski jezik
Vi imate pravo na besplatnog prevodioca. Molimo vas da pokazete na vas govorni jezik. Lagalan prevodilac oe biti pozvan. Hvala I molimo vas da sacekate.

Somali
Soomaali
Waxaad xaq u leedahay in tarjumaan lacag la'aan ah laguugu yeero. Fadlan farta ku fiiq luqaddaada. Tarju-maan ayaa laguugu wacayaa. Ee fadlan sug!

Spanish
Español
Usted tiene derecho a un intérprete gratis. Por favor, señale su idioma y llamaremos a un intérprete. Por favor, espere.

Swahili
Swahili
Ni haki yako kuwa na mtafsiri bila malipo yoyote. Tafadhali chagua lugha yako kati ya hizi. Mtafsiri ataitwa. Tafadhali ngoja.

Tagalog
Tagalog
Ikaw ay may karapatan na magkaroon ng tagapagsalin na walang bayad. Ituro ang iyong wika. Ang tagapagsalin ay tatawagin. Maghintay.

Thai

(THIS FORM IS AVAILABLE IN LARGER FONT OR ALTERNATIVE FORMAT UPON REQUEST)

PLEASE PRINT CLEARLY

Head of Household: ____ **TDD/Phone:** _______________

Address: ____ **State/Zip:** _________________

Currently, I am:

- ❐ **An applicant on the waiting list for The Housing Choice Voucher (Section 8) Program**
- ❐ **Currently a participant in the Housing Choice Voucher (Section 8) Program**

Household member who needs accommodation: ____

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The household member above has a disability because he or she has a physical or mental impairment that limits one or more major life activities or has a record of having such impairment.

Please fill out all the following information regarding the person who needs the accommodation(s). It is important for you to provide this detail in order for the Housing Authority of Beaumont to best evaluate this request. *Please DO NOT submit medical records.*

BHA can assist with completing this form. If you need assistance, contact the ADA/504 Coordinator at 409-951-7251 or email at hcs03@bmtha.org.

As a result of this disability, I am requesting the following reasonable accommodation(s) for the disabled Household Member listed above. Please check one or more boxes below.

❒ A extra bedroom to for medical equipment or other listed _____

_____

❒ A live-in aide is necessary to afford the Household Member equal use and enjoyment of the dwelling unit. Please answer the following question. Use the space below and additional paper if needed. A daily in-home worker, or rotating shifts, are not equally effective as a reasonable accommodation because:_____

_____

❒ A change in the following rule, policy or procedure. (Note that fundamental requirements must still be met). Please specify the necessary change. Attach additional pages if necessary._____

_____

❒ Other (for example, a change in the way PHA communicates with you). Please specify the necessary change. Attach additional pages if necessary. _____

_____

_____The purpose of an accommodation is to remove or relieve a barrier posed by the disability-related limitation. The disabled Household Member needs this reasonable accommodation(s) because (you may attach additional pages if necessary):_____

_____

_____

_____

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

FRAUD AND FALSE STATEMENTS

Title 18, Section 1001 of the U.S. Code states that a person who knowingly and willingly makes false and fraudulent statements to any department of the United States Government, including the Department of Housing and Urban Development (HUD), a public housing authority (PHA), and any owner (or employee of HUD, the PHA, or the owner) may be subject to penalties that include fines and/or imprisonment.

HOUSING AUTHORITY
of the City of Beaumont, Texas

AUTHORIZATION

I/we authorize the Housing Authority of Beaumont to verify that the above-referenced Household Member has a disability and needs the reasonable accommodation(s) requested. To verify this information, the HA may contact the below-named physician, psychiatrist, licensed psychologist, licensed nurse-practioner, licensed social worker, rehabilitation professional, or non-medical service agency whose function is to provide services to persons with disabilities. I understand the information PHA obtains will be kept completely confidential and used solely to evaluate the request.

This authorization is requested because third-party verification may be needed. Be advised that you may submit any supporting documentation directly to PHA rather than having PHA contact your provider, in order to evaluate your request.

Name of Provider: _____ Field of Practice: _____

Agency/Clinic/Facility: _____

Address: _____

Phone: (____) _____ FAX: (___) _____

X _____ _____

Signature of Head of Household or authorized Guardian ** Date

**** If the Household Member needing the accommodation(s) is under 18 years of age, do you the parent or guardian of Household Member need the accommodation? ❒ Yes ❒ No**

X _____ _____

Signature of Household Member needing the accommodation
(only if 18 years of age or older) Date

Please return this form as promptly as possible so that the Housing Authority of the City of Beaumont may make a determination on this request.

_____

Housing Specialist Date Received Request

_____

Phone Number Fax Number Email Address

_____

Date Given To 504 Coordinator Result of Request for Accommodation

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Information Request from Health Care Professional

A. Does your client meet eligibility requirements for a live-in aide (does he/she have a physical or mental impairment that substantially limits one or more major life activities, or is he /she 50 years of age or older)?

□ YES
□ NO

B. Live-in aide request:

In reviewing the client's file is it your professional opinion the live-in aide is necessary to afford the client an equal opportunity to use and enjoy the unit?

□ YES
□ NO

A daily in-home worker would not be an equal alternative accommodation because (please explain):_____

_____

C. Extra Bedroom Request

It is my professional opinion that the client does require an additional bedroom for:

□ A Live-in Aide
□ Medical equipment or assistive device
□ Other reason (please explain):

It is my professional opinion that the client does not require an additional bedroom because:

□ Necessary service could be provided through another accommodation
□ Client does not meet the definition of a disabled or near-elderly person
□ Medical equipment could be used/stored in a place other than an additional bedroom

Name of Health care Provider (please print) _____

Signature Date _____

Title License# _____

Address _____

City/State/Zip_____

Phone_____

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