REASONABLE ACCOMMODATIONS AND MODIFICATIONS NOTICE

Notice to All Applicants and Residents: Reasonable Accommodations and Modifications are available for Applicants and Residents with Mental and/or Physical Disabilities

The Lynn Housing Authority and Neighborhood Development (LHAND) does not discriminate against applicants or residents on the basis of mental (including psychiatric) or physical disabilities. In addition, the LHAND has an obligation to provide "reasonable accommodations" and "reasonable modifications" on account of a disability if an applicant or resident or a household member is limited by the disability and for this reason needs such an accommodation or modification. A reasonable accommodation is a change that the LHAND can make to its rules, policies, practices, or services, and a reasonable modification is a change that the LHAND can make to its facilities (including physical alterations to the housing unit or public or common use areas) that will assist an otherwise eligible person with a disability to have equal opportunity to use and enjoy the housing or common or public use areas or to participate fully in the LHAND's programs, activities, or services. Such changes may not be reasonable if they are not financially and programmatically feasible for the housing authority.

An applicant or resident household which has a member with a mental and/or physical disability must still be able to meet essential obligations of tenancy (for example, the household must be able to pay rent, to care for the apartment, to report required information to The LHAND, and to avoid disturbing neighbors), but an accommodation or modification may be the basis by which the household is able to meet those obligations of tenancy.

The LHAND has an Accommodation Coordinator. If you need an accommodation or modification because of a disability, please complete the attached form and return it to: **Lynn Housing Authority & Neighborhood Development, 10 Church Street, Lynn, MA 01902, ATTENTION: Carly McClain**. Upon reasonable request by the LHAND, you must also submit documentation verifying the existence of a disability and the disability-related need for the accommodation or modification. Within thirty (30) calendar days of receipt of your request and documentation, the Accommodation Coordinator will contact you to discuss what the LHAND can reasonably do to provide you an accommodation or modification on account of your disability.

If you or a member of your household has a mental and/or physical disability, and as a result needs an accommodation or modification, you, the household member, or authorized representative, may request it at any time. However, you are not obliged to make such a request, and if you prefer not to do so that is your right.

REQUEST FOR REASONABLE ACCOMMODATIONS/MODIFICATIONS RELEASE OF INFORMATION AUTHORIZATION

____
Applicant/Resident Name

____
Address City State Zip Code

________________________________ ________________________________
Phone Number Date of Birth

________________________________ ________________________________
Housing Program Case Representative's Name

To: Carly McClain, Reasonable Accommodation Coordinator
Lynn Housing Authority & Neighborhood Development
10 Church Street
Lynn, MA 01902

I am requesting the following reasonable unit modification and/or reasonable accommodation to LHAND policies and/or procedures so that I may have an equal opportunity to use and enjoy a dwelling unit, including public and common areas:

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____

The change that I am requesting will accommodate my disability in the following ways:

____

____

____

Name and Title of Medical Professional: ________________________________

Address: ____

Phone number: ____________________ Fax number: ______________________

Email Address: ____

I give permission to the Medical Professional listed above to communicate with the Lynn Housing Authority & Neighborhood Development (LHAND), and to disclose information from their records concerning my care and treatment. This authorization is limited to information necessary to determine whether the accommodation that I am requesting is medically necessary to accommodate my disability, for the reasons that I have described above.

I hereby waive and release the Medical Professional listed above from any liability, which they might otherwise incur, and from any restrictions, which might be imposed upon them by law as the result of such disclosures.

This authorization is valid for sixty (60) days. A photocopy of this authorization shall be as effective as the original.

Applicant/Resident Signature: ______________________________ Date:______________

REQUEST FOR REASONABLE ACCOMMODATIONS/MODIFICATIONS RELEASE OF INFORMATION AUTHORIZATION

____
Aplicante/Nombre de Residante

____
Dirección Ciudad Estado Código postal

______________________ ______________________
Número de Telephono Fecha de nacimiento

______________________ ______________________
Su Programa de Housing Nombre del representante del caso

Para: Carly McClain Reasonable Accommodation Coordinator
Lynn Housing Authority & Neighborhood Development
10 Church Street
Lynn, MA 01902

Yo estoy solicitando los siguientes cambios razonable a la unidad y/o acomodacion de acuerdo con directivas de LHAND y/o procedimientos para que yo tengo un opportunidad igual a usar y disfrutar una unidad de vivienda, incluyendo áreas público y común:

____
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____
____

El cambio que yo estoy solicitando vas a acomodar mi desibilidad en las siguientes maneras:

____
____
____
____

Nombre y Titelo de su Medico Professional: ______________________________

Dirección: ______________________________

Número de Teléfono: ________________ Número del Fax: ________________

Correo Electrónico: ______________________________

Le doy permiso al Médico Professional nombrado arriba para communicar con Lynn Housing Authority & Neighborhood Development (LHAND), y para revelar información de su expidientes relativos a mi cuidado y tratamiento. Esta autorización se limita a información necesaria para decidir si el alojamiento que yo estoy pidiendo es médicamente necesario para acomodar mi desibilidad, para las razones he escrito arriba.

Por el presente renuncio y libero el Médico Professional nombrado arriba de cualquier responsabilidad, en que podrían incurrir, y de cualquier restrictciones, que podría ser impuesta a ellos por ley como resultado de tales divulgaciones.

esta autorización es válida por (60) días. Una foto copia de esta autorización será eficaz como el original.

Firma de Aplicante/Residente: ______________________ Fecha: ____________