



CARIBOU HOUSING AGENCY

Housing Choice Voucher Program

25 High Street

Caribou, ME 04736

Telephone: (207) 493-4234

Fax (207) 376-0178

www.cariboumaine.org



REASONABLE ACCOMMODATION QUESTIONNAIRE

This form is to be completed by the Head of Household, or Power of Attorney (copy of POA needs to be attached).

Head of Household: _____

Address: _____

City: _____ Phone Number: _____

CURRENTLY, I AM:

- ☐ An applicant on the waiting list for the Housing Choice Voucher (Section 8) Program.
- ☐ A participant in the Housing Choice Voucher (Section 8) Program.

Household member who needs an accommodation: _____

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

TO REQUEST A REASONABLE ACCOMMODATION

A. Related to a specific unit, check all that apply.

- ☐ An extra bedroom for a 24-hour live-in aide. (additional documentation required)
A daily-in home worker, or rotating shifts are not equally effective as a reasonable accommodation because: _____
- ☐ A separate bedroom for medical equipment (size of equipment may not warrant a separate bedroom)
I cannot use/store the medical equipment in current bedroom because: _____
- ☐ A separate bedroom for the person with a disability (additional documentation required)
Separate bedroom for the person is necessary because: _____
- ☐ Approval to rent a unit owned by a relative who helps you with your daily living needs. (additional documentation required)
Relative assist me with _____
- ☐ Other: (please explain): _____

B. If asked to come to the Housing Agency office, please check all that apply.

- ☐ A home visit (because you are too ill/unable to come to the office)
- ☐ An interpreter for:
- ☐ Sign Language
- ☐ Language Interpreter, please specify language: _____
- ☐ A reader to read documents for you
- ☐ Other (please explain): _____
- _____

I/We hereby authorize the Caribou Housing Agency to verify that the above-reference Household Member has a disability and needs the reasonable accommodation(s) requested. To verify the information, the Housing Agency may contact the below named licensed physician, psychiatrist, nurse-practitioner, social worker, rehabilitation professional, or other licensed professional whose function is to provide services to persons with disabilities. I understand the information that Caribou Housing Agency obtains will be kept completely confidential and used solely to evaluate the request.

This authorization is requested because third-party verification may be needed.

Name or Provider: _____ Field of Practice: _____

Agency/Clinic/Facility: _____

Mailing Address: _____

Phone: _____ Fax: _____

CERTIFICATION:

WARNING: Section 1001 of Title 18 of the U.S. Code makes it a criminal offense to make willful false statements or misrepresentation to any Department or Agency of the United States.

X. _____

Signature of Head of Household or authorized Guardian/POA

Date

**** If the Household Member needing the accommodation(s) under 18 years of age, are you the parent or guardian of Household Member needing the accommodation? ☐ Yes ☐ No**

X. _____

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

Date

****If you or anyone in your household is a person with disabilities, and you require a specific accommodation in order to fully utilize our programs and services, please contact the Caribou Housing Agency.****