

**DEPARTMENT OF SOCIAL SERVICES
Section 8 Housing Choice Voucher Program**

Dr. Robert L. Yeager Health Center
50 Sanatorium Rd., Building L
Pomona, New York 10970
(845)364-3331 Fax (845) 364-3222

Joan M. Silvestri
Commissioner

Reasonable Accommodation Verification

Household Member Name: _____ **SS# (last 4 digits)** _____

The Authorization for the Release of Information (HUD-9886) or the Consent for Release of Information form is attached.

This individual has applied for housing assistance under a program of the U.S. Department of Housing and Urban Development (HUD). HUD requires us to verify all information that is used in determining the family's eligibility.

We appreciate your prompt response, as we are required to complete our verification process in a short time period. Please respond by: the included self-addressed envelope, faxing this form to 845-364-3222, or emailing it to rocklandhcv@dfa.state.ny.us. Please do not hesitate to contact us with any questions at 845-364-3331. Thank you in advance for your cooperation.

VERIFICATION OF REASONABLE ACCOMMODATION
(TO BE COMPLETED BY A KNOWLEDGEABLE PROFESSIONAL)
Please provide the following information for the individual listed below.

Name of Household Member requesting reasonable accommodation		
<input type="checkbox"/>	I certify that the above-named individual is a person with a disability. In order to participate fully in the Housing Choice Voucher program, this individual requires the following reasonable accommodation:	
	This individual requires this accommodation because: <i>(Please do not provide specific information about diagnoses, tests, or treatments provided. Names and descriptions of any equipment is recommended.)</i>	

I certify that the information provided is true and correct.

Name of Individual Completing Form		Title	
Signature		Company	
Address			Date
Email		Telephone	