

**Saginaw Housing Commission**  
**1803 Norman Street P.O. Box 3225**  
**Saginaw, MI 48605-3225**  
**989-755-8183 FAX: 989-754-3139**  
**TDD: 989-755-1880**

**REASONABLE ACCOMODATION REQUEST**

I (or a member of my household) am (is) a person with a disability as defined by one or more of the following: A physical or mental impairment that substantially limits one or more life activities; or a record of having such impairment; or is regarded as having such impairment.

Name \_\_\_\_\_ Date \_\_\_\_\_

Name of family member who needs accommodation \_\_\_\_\_

Address \_\_\_\_\_ Phone Number \_\_\_\_\_

As a result of this disability, I request the following reasonable accommodations: \_\_\_\_\_

\_\_\_\_\_

The request is necessary so that I can: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ I will make those alterations to the apartment

\_\_\_\_\_ I request that the Housing Authority make those alterations to the apartment.

\_\_\_\_\_ I prefer to move to a unit that better fits my needs.

\_\_\_\_\_ The request is for a change in a rule, policy or procedure

Verification of the disability-based need for the requested accommodation may be required. I authorize the Saginaw Housing Commission to verify that I, or someone in my household, have a disability and the need for the reasonable accommodation requested. To verify this information the SHC may contact the following licensed health care professional, physician, a social service professional, disability agency or clinic. You may present verification directly to the SHC in addition to completing this request form.

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Name: \_\_\_\_\_ Title \_\_\_\_\_

Agency/Clinic/Facility \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_

Signed \_\_\_\_\_ Date \_\_\_\_\_

(Head of Household or individual with the disability if over 18)

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*For Saginaw Housing Commission Use Only*

Date request received by SHC \_\_\_\_\_

Date of interview with Resident or other information requested (within 20 business days) \_\_\_\_\_

Decision of SHC (letter to be sent within 30 business days/attach coy of letter) \_\_\_\_\_

Date Resident notified that request was approved or denied \_\_\_\_\_

Date reasonable accommodation completed \_\_\_\_\_