HOUSING AUTHORITY OF AUGUSTA, GEORGIA VERIFICATION OF DISABILITY

Name:_____ Date:_____

Address:_____

_____

Dear Resident/Applicant:

You have indicated that you, or a member of your household, need a reasonable accommodation because of a disability in connection with an Augusta Housing Authority residence, facility, program or service. A physician, licensed health care professional, or a professional representing a social service agency or disability agency or clinic may verify this information.

Please take this letter, the attached Authorization for Release of Information and the enclosed pre-addressed envelope to your health care provider or other appropriate individual, clinic or agency. The Augusta Housing Authority will use this information to evaluate your request for a reasonable accommodation. The Augusta Housing Authority will keep this information confidential. If you choose not to authorize the release of this information, we may not be able to consider your reasonable accommodation request(s).
MODIFICATION/ACCOMMODATION REQUESTED: