



# HOUSING AUTHORITY

OF THE CITY OF KEY WEST, FLORIDA

## Request for a Live-in Aide and/or Extra Bedroom

Name: \_\_\_\_\_ TDD/Phone: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State/Zip: \_\_\_\_\_

Currently, I am (check one):

- An applicant or applying for a housing unit with this Housing Agency
- A Section 8 Voucher holder searching for a unit
- Housed in one of the units owned and/or managed by this Housing Agency

Name of disabled or elderly/near-elderly household member requesting accommodation: \_\_\_\_\_

- The household member is a person with a disability or is elderly/near elderly (***check all that apply***):
  - The person receives SSI or SSDI.
  - The person is disabled and/or handicapped.
  - A health care professional will certify on a verification form that the person is disabled.
  - The person is elderly or near elderly.

### Live-in Aide request (*skip if aide is not required*):

- A live-in aide is necessary to afford the household member equal use and enjoyment of the dwelling unit because:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- A daily in-home worker is not equally effective as a reasonable alternative accommodation because:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Bedroom request:

- The household currently lives in a \_\_\_\_\_ bedroom unit. We are requesting to:
  - Keep our current unit where we are considered overhoused for now.
  - Be upgraded to a larger bedroom subsidy and move to a larger unit.

- The household member requests the additional bedroom for a live-in aide.
- The household member requests the additional bedroom for medical equipment because of its size/function. If you answer yes to this you must describe below.

Describe medical equipment ***dimensions and/or functional*** requirements:

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Describe why the current unit (***including living room***) is inadequate:

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The household member needs an extra bedroom as a disability accommodation because (***please specify if not explained above***):

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You may verify the disability and the need for this request by contacting the following knowledgeable professional:

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

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State/Zip: \_\_\_\_\_

I give permission to contact the above individual for purposes of verifying that I (or a family member) have a disability and need the reasonable accommodation requested above. I understand that the information you obtain will be kept completely confidential and used solely to determine whether or not you will provide an accommodation.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Person with disability or legal guardian)

***WARNING: Title 18, section 1001 of the United States code states that a person is guilty of a felony for knowingly and willingly making false or fraudulent statements to any department or agency of the United States.***

## Staff Verification:

The above referenced client:

is disabled

\_\_\_\_\_ is handicapped

\_\_\_\_\_ is elderly

has received prior reasonable accommodation approval

\_\_\_\_\_ is identified as LEP

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Housing Manager/Specialist)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Housing Manager/Specialist's Supervisor)

## Notes: