REQUEST FOR REASONABLE ACCOMMODATION

NOTE: This form is to be completed and signed by the Member on behalf of the authorized occupant needing the accommodation. Please complete a separate "Request for Reasonable Accommodation" form for each authorized occupant requiring an accommodation.

If the disabled authorized occupant who needs the accommodation is 18 years of age or older, he or she AND the Member must sign this form.

Member: ______________________________

Authorized Occupant Who Needs an Accommodation: ______________________________

Relationship to Member: ______________________________

Address: ______________________________

Telephone Number: ______________________________

I certify the authorized occupant has a disability because he or she has a physical or mental impairment that substantially limits one or more major life activities or has a record of having such an impairment.

1. As a result of this disability, I am requesting the following reasonable accommodation from Highlands Cooperative (please provide details): List the service(s) you are requesting not your disability (impairment).

   ____
   ____
   ____
   ____
   ____

2. The disabled authorized occupant needs this reasonable accommodation because (identify functional limitations for which you seek accommodation): ______________________________

   ____
   ____
   ____
   ____

3. For transportation, we mostly rely on (please check off one):

   ☐ My Car ☐ Public Transportation ☐ Walking
   ☐ Friend or Family Member ☐ Other (please specify): ______________

4. If you have any additional information you wish to provide, you may use the space below or attach additional pages if necessary. ______________

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AUTHORIZATION

I/We authorize Highlands Cooperative to verify that the above-referenced authorized occupant has a disability and that we need the reasonable accommodation requested. To verify this information, Highlands Cooperative may contact the below-named physician, psychiatrist, licensed psychologist, licensed nurse practitioner, licensed social worker, rehabilitation professional, or non-medical service agency whose function it is to provide services to the disabled. (NOTE: This authorization is requested because third-party verification may be needed. Be advised that you may submit any supporting documentation directly to Highlands Cooperative rather than having Highlands Cooperative contact your provider, in order to facilitate the evaluation of your request).

Name of Provider: ________________________________ Field of Practice: ______________
Agency/Clinic/Facility: ____
Address: ____
City:_________________________ State: __________________ Zip Code:_______________
Telephone: ____________________________ Fax: _______________________________

____ ______________________
Member's Signature Date

____ ______________________
Authorized Occupant's Signature Date
(only if 18 years of age or older)