

REQUEST FOR REASONABLE ACCOMMODATION PACKET

This packet contains the forms necessary to request a reasonable accommodation from the Houston Housing Authority (“HHA”). In order to help avoid misunderstandings regarding what is being requested HHA prefers all requests for accommodation to be put in writing. If an individual is unwilling to provide a request in writing, or to sign a request, HHA will document the request and review it based solely on the information provided.

Prior to determining whether the requested accommodation(s) is/are reasonable and necessary, your Health Care Provider must verify that your impairment meets the legal definition of disability and that you require the requested accommodation based on your disability. Once you have determined that you require an accommodation, it is your responsibility to ensure that all the necessary forms have been completed and submitted to HHA (forms must be submitted in one complete package, or your request may not be processed), as outlined below:

STEP 1. FORM #1 – REQUEST FOR ACCOMMODATION (“Request”): You must complete this form, indicating which member of the household is disabled (indicate “SELF” if you are the disabled individual). You must also state the accommodation(s) you are requesting. YOU MUST SIGN THIS FORM AS HEAD OF HOUSEHOLD. IF YOU ARE NOT THE DISABLED INDIVIDUAL, THE DISABLED PERSON MUST ALSO SIGN THE FORM, UNLESS THEY ARE UNDER 18 YEARS OF AGE.

STEP 2. FORM #2 – HEALTH CARE PROVIDER’S VERIFICATION OF NEED FOR AN ACCOMMODATION IN HOUSING BECAUSE OF A DISABILITY (“Verification”): You must fill in all lines in Section A of the Verification. After you have filled out Section A, you must submit the Verification to your Health Care Provider, along with Form #1 – Request and the Health Care Provider Instruction Sheet (attached). Have your Health Care Provider fill out Section B of the Verification and sign the form. Please ask your Health Care Provider to carefully read the instruction sheet to ensure they complete the form appropriately.

STEP 3. Return Forms 1 and 2, together, to: Houston Housing Authority, ATTN: Legal Compliance Officer, 2640 Fountain View Drive, Houston, Texas, 77057 or by email to 504ada@housingforhouston.com.

NOTE: If assistance is required to complete Form 1 or Section A of Form 2, please contact a HHA employee in the department from which you obtained this form (e.g., Housing Specialist, Property Manager, Legal Compliance Officer). After this form has been completed, you must take Forms #1 and #2 to your Health Care Provider, HHA will not send this form to your Health Care Provider.

After HHA receives the completed forms, which must be signed by both you and your Health Care Provider, a decision will be made regarding your request. If an individual refuses to sign the form authorizing HHA to contact the Health Care Provider to verify or obtain necessary information, HHA may be unable to verify whether the requested accommodation is necessary based on the individual’s disability and the request may be denied. HHA has thirty (30) business days in which to respond to your request. **Please note that HHA makes every attempt to respond promptly, so phone calls regarding the status of your application further delay the review process for all applicants.** Any additional information necessary to consider your request will be made in writing. Finally, HHA will send you an approval or denial of your request, in writing.

NOTICE OF AVAILABILITY OF REASONABLE ACCOMMODATION

It is the Houston Housing Authority's ("HHA") policy to provide "reasonable accommodation" in housing for applicants, public housing residents, and Section 8 clients with disabilities who are otherwise qualified for HHA's housing programs. This policy is in furtherance of HHA's goal of providing affordable housing to low-income persons regardless of disability and in compliance with applicable federal, state, and local law.

A person with a disability is one who (1) has a physical or mental impairment that substantially limits one or more major life activities; (2) has a record of such an impairment; or (3) is regarded as having such an impairment.

A "reasonable accommodation" is a modification or change the HHA can make to its rules, policies, practices or services, or modifications to the person's apartment or to a public/common area where such is necessary to provide a person with a disability an equal opportunity to participate in, or benefit from, HHA housing programs. Examples of a reasonable accommodation include, but are not limited to, the following:

- A transfer to a unit with wheelchair access;
- Installation of strobe-type flashing light smoke detector in a HHA housing unit for the hearing-impaired;

A reasonable accommodation may also include provision of an appropriate auxiliary aid where such assistance is necessary to enable effective communication between the applicant, public housing resident or Section 8 client and HHA.

You may obtain a Request for Reasonable Accommodation form from HHA at:

504ada@housingforhouston.com

You may also request that the form be sent to you by contacting your intake specialist, property manager, or housing specialist, or by logging on to www.housingforhouston.com

If you have questions or problems, please contact the Legal Compliance Officer by email at 504ada@housingforhouston.com or by mail at Houston Housing Authority, ATTN: Legal Compliance Officer, 2640 Fountain View Drive, Houston, Texas, 77057.

NOTICE OF AVAILABILITY OF ALTERNATIVE FORMS OF COMMUNICATION

If you have a disability and require an alternative form of communication including, but not limited to, sign-language interpreter or assistance completing forms, you may seek assistance with customer service by phone 713-260-0500 or in person with the lobby representative at 2640 Fountain View Houston, TX 77057 or email the Legal Compliance Officer at 504ada@housingforhouston.com.

Si necesita ayuda en español, comuníquese con su especialista en vivienda / admisión o

lep@housingforhousingforhouston.com.

FORM #1
REQUEST FOR ACCOMMODATION
DO NOT RETYPE OR ALTER THIS FORM IN ANY WAY

Si necesita ayuda en español, comuníquese con su especialista en vivienda / admisión o

lep@housingforhousingforhouston.com.

NAME: _____ TELEPHONE NO.: _____

CLIENT NUMBER: _____

ADDRESS: _____

CITY, STATE, ZIP CODE: _____

EMAIL ADDRESS: _____

PROGRAM: PUBLIC HOUSING: _____ SECTION 8: _____ ARE YOU AN APPLICANT? YES NO

- **REQUIRED INFORMATION:** *The following member of my household has a disability, i.e., a physical or mental impairment that substantially limits one or more life activities.*

Name: _____ Date of Birth: _____

Relationship or association with you: _____

- (If applicable) I authorize HHA to contact the following individual who assisted me in the completion of this form:

Name: _____ Telephone: _____

Address: _____

City, State, Zip Code: _____

Email address: _____

- **REQUIRED INFORMATION:** I authorize HHA to verify that I or member of my household has a disability and need the accommodation I have requested. In order to verify this information, HHA may contact the following Health Care Provider:

Name: _____

Title of Health Care Provider: _____

Agency, Facility or Institution (if any): _____

Address: _____

City, State, Zip Code: _____

Telephone: _____ Fax: (required) _____

Email address: _____

- I authorize the Health Care Provider to release any information necessary to assess the Applicant's request for an accommodation(s) including the medical information requested in Form #2 to the Houston Housing Authority ("HHA").

Signed: _____ Date: _____

(Head of Household or Authorized Representative)

Signed: _____ Date: _____
(Individual with the Disability, if Over 18)

I understand that the information obtained by HHA will be kept completely confidential, to the extent permitted by law, and used solely to make a determination regarding my accommodation request.

■ **REQUIRED INFORMATION:** *As A Result Of This Disability, I Am Requesting The Following Accommodation:* (Please check one or more boxes below):

A change in my apartment or the public or commons areas of the housing development (Public Housing Residents Only). Please explain why the requested change is necessary and specifically state the change you are requesting:

An exception to a rule, policy, practice or service. (You may request a change that you believe will allow you to comply with the terms of the lease or voucher, but everyone is required to comply with the essential terms of their lease or the voucher program.) Please explain why the exception you are requesting is necessary, and specifically identify the exception you want HHA to make.

Other (for example, a change in the way HHA communicates with you). Please specify:

A Live-in Aide. If you are requesting an additional bedroom to accommodate a Live-In Aide please answer the following questions:

1. Is the proposed Live-In-Aide a relative/spouse/domestic partner/common law spouse/significant other of the Applicant?

[] YES [] NO

2. Please provide the name of the proposed Live-In-Aide and explain the relationship between the Live-in-Aide and the Applicant.

Name: _____

Relationship: _____

3. Does the proposed Live-In-Aide currently live with Applicant?

YES NO If you marked NO, please provide the Live-in-Aide's current address:

Address: _____

Has the proposed Live-In-Aide ever lived with Applicant?

YES NO If you marked YES, please explain in detail:

Will the Live-In-Aide be paid to provide health and/or supportive care services?

YES NO

4. Will the Applicant's address be the only residence of the proposed Live-In-Aide?

YES NO

If you marked NO, please explain how many nights a week the Live- In-Aide will stay with the Applicant:

5. Is the proposed Live-In-Aide working full-time or going to school full-time?

YES NO If you marked YES, please explain in detail:

- **REQUIRED INFORMATION:** *This Accommodation Is Necessary So That I Can:* (Please state how the accommodation will provide you with an equal opportunity to participate in, or benefit from, HHA housing programs.)

Signed: _____ Date: _____
(Head of Household or Authorized Representative)

Signed: _____ Date: _____
(Individual with the Disability, if Over 18)

NOTE: HHA REQUESTS THE ABOVE INFORMATION IF IT BECOMES NECESSARY TO VERIFY OR COMPLETE YOUR FILE. YOU MUST HAVE YOUR HEALTH CARE PROVIDER COMPLETE FORM #2 - HEALTH CARE PROVIDER VERIFICATION FORM ATTACHED TO THIS REQUEST.

This form and the completed Health Care Provider Verification Form #2 must be submitted to Houston Housing Authority, ATTN: Legal Compliance Officer, 2640 Fountain View Drive, Houston, TX 77057, or by email at 504ada@housingforhouston.com.

If you have any questions regarding this form, please contact your housing specialist, property manager or Legal Compliance Officer.

**PLEASE READ THIS SHEET BEFORE
COMPLETING THE ATTACHED FORM**

**INFORMATION SHEET FOR COMPLETING THE HEALTH CARE PROVIDER'S VERIFICATION OF NEED
FOR AN ACCOMMODATION IN HOUSING BECAUSE OF A DISABILITY FORM**

The Houston Housing Authority ("HHA") is a federally funded program. Therefore, the Americans with Disabilities Act ("ADA") and Section 504 of the Rehabilitation Act of 1973 ("Section 504") require HHA to provide reasonable accommodations to qualified program applicants or participants of the Section 8 and public housing programs (herein referred to as "Applicant"). HHA may verify that the requested accommodation is necessary to give the Applicant an equal opportunity to participate in, or benefit from, HHA housing programs. HHA has implemented a process to review requests for accommodations submitted by the Applicant. The attached form provides HHA with verification of the Applicant's disability, and the necessity of the requested accommodation.

Please note that a health care provider is not required to use Form #2. Alternatively, a health care provider may submit a letter supporting the Applicant's request on your letterhead and signature. Please be advised this letter must state with sufficient clarity: (1) whether the Applicant qualifies as disabled as described below; (2) what accommodation is requested; and (3) must describe the relationship, or nexus, between the requested accommodation and the Applicant's disability.

HHA may also verify the Applicant's disability only to the extent necessary to ensure that the Applicant has a need for the requested accommodation. Therefore, **DO NOT provide medical records, or specify the Applicant's disability, or provide any specific details about the nature of the disability in your response.** HHA requires documentation of the manifestation of the disability that causes a need for the requested accommodation.

WHAT QUALIFIES AS A DISABILITY?

A person with a disability is one who:

1. Currently has a physical or mental impairment that substantially limits one or more major life activities; or
2. Has a record of such an impairment; or
3. Is regarded as having such impairment.

This definition may differ from the medical definition of "disability." However, this is how "disability" is defined by the ADA and Section 504, and is the definition you **must** use in evaluating and certifying whether the Applicant meets the definition of a person with a "disability." You **must** strictly interpret and apply this legal definition. The key words in this definition are, "substantially limits" one or more "major life activities."

The United States Supreme Court has ruled that a person is "substantially limited" in performing a major life activity only if the impairment, on a permanent or long-term basis, prevents or severely restricts the Applicant from engaging in certain major life activities. A major life activity is "substantially limited" if the Applicant is unable to perform a particular life activity that the average person in the general population can perform, or is significantly restricted in "the condition, manner, or duration" under which he/she can perform a particular life activity as compared to an average person in the general population. If the impairment interferes only in a minor way or for a short period of time with the performance of a stated major life activity, the Applicant may not, in some circumstances, be considered disabled if the impairment is not "substantially limiting."

Based on this definition, it is clear that any number of impairments may not fall within the legal definition of “disability,” in which case the Applicant is not qualified for an accommodation. Physical or mental impairment does not include simple physical characteristics such as blue eyes or black hair, nor does it include environmental, cultural, economic or other disadvantages such as having a prison record. Your role, as the health care provider, is to provide HHA with your professional opinion regarding whether the Applicant’s current impairment meets the legal definition of a disability.

It is not possible to include a list of all the specific conditions or diseases that would or would not constitute a physical or mental impairment because of the difficulty of ensuring the comprehensiveness of such a list; however below are some qualifying mental and physical impairments, and a list of some of the exclusions under the law.

Qualifying Mental and Physical Impairments:

1. A mental impairment includes, but is not limited to, mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.
2. A physical impairment includes, but is not limited to, cosmetic disfigurement; anatomical loss affecting the neurological, musculoskeletal, sensory, respiratory, cardiovascular, or reproductive, digestive, hemic, lymphatic or skin systems; or AIDS or HIV Positive.
3. A mental or physical impairment includes, but is not limited to, cerebral palsy, autism, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, alcoholism or drug addiction.

Exclusions from protection:

The following disabilities are explicitly excluded from the definition of disability:

1. Sexual behaviors or traits such as homosexuality, bisexuality, transvestitism, voyeurism, transsexualism, and gender identity disorders not resulting from physical impairments.
2. Compulsive gambling, kleptomania and pyromania.
3. Psychoactive substance use disorders resulting from current illegal use of drugs.

However, a diagnosis of an impairment alone is not determinative of whether an Applicant is disabled. As explained below, the impairment must severely restrict one or more of the Applicant’s major life activities. As the Applicant’s Health Care Provider, you must provide HHA information regarding how severely the Applicant’s major life activities are affected by their impairment. For example, an Applicant diagnosed with an impairment of diabetes may or may not be disabled. If the Applicant has lost their eye sight because of the diabetes, they may be disabled because their major life activity of seeing is substantially limited by the impairment of diabetes. On the other hand, if the Applicant simply has to monitor their glucose levels and the diabetes does not substantially limit their major life activities they are not disabled.

WHAT QUALIFIES AS A “MAJOR LIFE ACTIVITY”?

“Major life activity” refers to those activities that are of central importance to most people’s daily lives. The tasks in question must be central to daily life. It is insufficient for Applicants attempting to prove disability status under the ADA or 504 to merely submit evidence of a medical diagnosis of an impairment. Instead, to prove a disability they must offer evidence that their performance of a major life activity is severely restricted as to condition, manner, or duration under which such activity can be performed in comparison to the average person in the general population.

WHAT DOES “REGARDED AS HAVING SUCH AN IMPAIRMENT” MEAN?

A person is “regarded as” disabled within the meaning of the ADA if: (1) a covered entity mistakenly believes that a person has an impairment that substantially limits one or more major life activities, or (2) a covered entity mistakenly believes that the person’s actual, non-limiting impairment substantially limits one or more major life activities. As a recipient of federal funds, HHA is a covered entity. The fact that HHA is engaged in this process with the Applicant is evidence that HHA does not mistakenly believe that the Applicant has an impairment that limits one or more major life activities. Nor does HHA mistakenly believe that the Applicant’s actual, non-limiting impairment substantially limits one or more major life activities. Note that this definition specifically states that the covered entity (i.e., HHA) must have the mistaken belief, not a physician, other members of the community, or other entities.

WHAT IS A REASONABLE ACCOMMODATION?

A reasonable accommodation is a modification to an Applicant’s unit, common or public areas of the facility, or a change in rules, policies, practices or services that will allow a person with a disability to have an equal opportunity to participate in, or benefit from, HHA housing programs.

An accommodation is not reasonable, simply because the Applicant is disabled. The accommodation must be reasonable and there must be an identifiable relationship, or nexus, between the requested accommodation and the Applicant’s disability. Therefore, you must provide your professional opinion and certify as to why the requested accommodation is necessary in order for the Applicant to have an equal opportunity to participate in, or benefit from, HHA housing programs, because of the Applicant’s disability.

On the attached form you must:

1. specifically identify the major life activities that are affected by the Applicant’s disability;
2. describe how these major life activities are substantially affected by the Applicant’s disability;
3. explain how the accommodation is directly related to the Applicant’s disability; and

PLEASE RETURN FORM #2 – HEALTH CARE PROVIDER VERIFICATION FORM, TO THE APPLICANT. THEY MUST SUBMIT THIS FORM, WITH THEIR REQUEST FOR ACCOMMODATION TO HHA. IF ADDITIONAL INFORMATION IS REQUIRED, HHA WILL CONTACT YOU DIRECTLY. HHA WILL VERIFY, BY FAX, THAT YOU HAVE COMPLETED FORM #2 – HEALTH CARE PROVIDER’S VERIFICATION. PLEASE NOTE THAT HHA CANNOT BEGIN PROCESSING THE APPLICANT’S REQUEST FOR REASONABLE ACCOMMODATION UNTIL HHA RECEIVES YOUR FAX VERIFICATION.

FORM #2
MEDICAL VERIFICATION FORM

HEALTH CARE PROVIDER'S VERIFICATION OF NEED FOR AN ACCOMMODATION IN HOUSING BECAUSE OF A DISABILITY

DO NOT RETYPE OR ALTER THIS FORM IN ANY WAY

SECTION A

Applicant's Name: _____

Address: _____

(Street Address, City, State, Zip Code)

Requested Accommodation: _____

SECTION B

The person named above is an Applicant for an accommodation because of disability, and is requesting that HHA provide them with the accommodation stated in Section A above. After you have completed this form, please return it to the Applicant, so they may submit the necessary forms to HHA for their request to be considered.

Health Care Provider must fill in all appropriate blanks below in this Section B. DO NOT ATTACH ANY MEDICAL RECORDS OR OTHER DOCUMENTATION REGARDING THE INDIVIDUAL'S DISABILITY. You must address these issues in your answers to the questions below. HHA cannot and will not interpret documentation regarding an individual's disability to determine if their disability requires the requested accommodation. As the health care provider, it is your responsibility to provide the necessary information regarding the individual's disability and how that disability is related to their Request for Accommodation. Before you complete this form, please read the attached information sheet so that you clearly understand what an accommodation is and how the law defines "disabled." If a question is not applicable write "N/A" next to the question.

Name of Health Care Provider: _____

Agency, Facility or Institution (if any): _____

Address: _____

City, State, Zip Code: _____

Telephone: _____ Fax: (required) _____

1. In my opinion, the Applicant has a disability as defined below. Please check any paragraph below that applies. **(If none of these apply, please go to Question 2)**

[] A. A physical or mental impairment that substantially limits one or more major

life activities.

B. A record of having such an impairment. If you check this box answer the following question:

(i) Identify the covered entity that has a record of the Applicant having an impairment that substantially limits one or more major life activities.

C. Is regarded as having such an impairment. If you check this box answer the following question:

(i) Identify the covered entity that mistakenly believes that the Applicant either has: 1) an impairment that substantially limits one or more major life activities; or, 2) an actual non-limiting impairment substantially limits one or more major life activities.

2. In my opinion this individual or applicant does not qualify as disabled as discussed above. **(Please go to the end of this form, read the certification and sign the bottom of this form.)**

3. Specifically identify the "major life activities" that are affected by the Applicant's physical or mental impairment. How often is the listed "major life activity" performed (daily, weekly, monthly, etc.)?

4. State, in detail, how the Applicant is significantly restricted in the condition, manner or duration under which he/she can perform the major life activities identified in Question 3, compared to the average person in the general population.

5. Does the Applicant have available to them any alternatives that would provide a similar accommodation for the Applicant's disability?

YES NO

If YES, please explain: _____

6. Will the Applicant require the accommodation permanently?

YES (Go to 7 below)

NO (Answer A below) **UNKNOWN** (Please answer B below)

A. If the required length of the accommodation is unknown when will the required length be determined?

B. If the disability status is unknown, when will the Applicant's disability status be determined?

How long will the Applicant be disabled?

7. In my opinion, the Applicant's disability requires that one or more of the following accommodation(s) be made in order for the Applicant to have an equal opportunity to participate in, or benefit from, HHA housing programs:

YES **(Please Answer A through D below)**

NO (Please go to the end of this form, read the certification and sign the bottom of this form.)

A. Specifically identify the accommodation(s) required.

B. Why does the Applicant need the requested accommodation(s)?

C. How is this accommodation(s) directly related to the Applicant's disability?

D. How will the requested accommodation(s) enable the Applicant to have an equal opportunity to participate in, or benefit from, HHA housing programs?

IF APPLICANT REQUIRES AN EXTRA BEDROOM FOR MEDICAL EQUIPMENT, PLEASE GO TO QUESTION 8.

IF APPLICANT REQUIRES AN EXTRA BEDROOM FOR A LIVE-IN-AIDE, PLEASE GO TO QUESTION 9.

IF APPLICANT REQUIRES AN ASSISTANCE ANIMAL, PLEASE GO TO QUESTION 10.

8. If the Applicant is requesting an extra bedroom to store medical equipment, please respond to the following questions: **(NOTE: EXERCISE EQUIPMENT MUST BE PRESCRIBED FOR THE APPLICANT'S DISABILITY AND CANNOT SIMPLY BE ANY EXERCISE EQUIPMENT THAT WOULD BE BENEFICIAL TO ANYONE'S GENERAL HEALTH.)**

A. Have you prescribed the medical equipment for the Applicant?

YES NO

B. Does the Applicant need medical equipment that requires storage in a separate location, other than the living room, bathroom, kitchen, or Applicant's bedroom(s)?

YES NO

C. List all medical equipment the Applicant has at home and the approximate size of the equipment.

D. Why must the Applicant store this equipment in a separate bedroom, instead of another room of the unit?

E. Where does the Applicant use the medical equipment? How often is it used?

F. Identify the relationship, or nexus, between the Applicant's request for an additional bedroom, the need for the medical equipment, and the Applicant's disability.

9. Federal regulations require HHA to allow, as a reasonable accommodation, a qualified person with a disability to have a Live-in-Aide (also referred to as a personal care provider, caregiver, nurse etc.) and approve one (1) additional bedroom for the Live-

In-Aide. A Live-In-Aide is a person who resides with one or more elderly persons or near-elderly persons, or persons with disabilities, and who:
(1) is determined to be essential to the care and well-being of the person(s); (2) is not obligated for the support of the person(s); and, (3) would not be living in the unit except to provide the necessary supportive services.

A. Does the Applicant have a disability that requires a Live-in Aide?

YES **NO**

If yes, please explain in detail:

B. The Live-In-Aide will provide health and/or supportive care services as follows:

C. The health and/or supportive care services are needed:

FULL-TIME **PART-TIME**

If Part-time, what hours of the day? From _____ to _____

D. How many nights a week are the health and/or supportive services needed?

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

10. Federal regulations require HHA to allow, as a reasonable accommodation, a qualified person with a disability to own and keep an “assistance animal” (also referred to as a service animal or companion animal), on HHA’s premises. An assistance animal is an animal that works, provides assistance, or performs tasks for the benefit of a person with a disability; or animals that provide emotional support that alleviate one or more identified symptoms or effects of a person’s disability. If the Applicant is requesting that they be allowed to keep an assistance animal, please answer the following questions:

A. Does the Applicant require an assistance animal as defined above?

YES NO

B. Identify the relationship, or nexus, between the Applicant’s request for an assistance animal and the Applicant’s disability.

I HEREBY CERTIFY THAT I HAVE READ THE INFORMATION SHEET FOR COMPLETING “FORM #2 – HEALTH CARE PROVIDER’S VERIFICATION OF NEED FOR AN ACCOMMODATION IN HOUSING BECAUSE OF A DISABILITY” AND I UNDERSTAND ITS CONTENTS. I FURTHER CERTIFY THAT ALL INFORMATION I PROVIDED IN THIS FORM IS ACCURATE, COMPLETE, AND CURRENT. FINALLY, I UNDERSTAND THAT I CAN BE SUBPOENAED TO TESTIFY IN ANY TRIALS OR HEARINGS RELATED TO THE APPLICANT’S REQUEST.

Signature of Health Care Provider

Date

Please provide your medical stamp or medical license number to verify this was completed by you.

WARNING: THERE ARE FINES AND IMPRISONMENT -- \$250,000/5 YEARS -- FOR ANYONE WHO MAKES FALSE, FICTITIOUS, OR FRAUDULENT STATEMENTS OR ENTRIES IN ANY MATTER WITHIN THE JURISDICTION OF THE FEDERAL GOVERNMENT (18 USC 1001). IN ADDITION, ANY PERSON WHO KNOWINGLY AND MATERIALLY VIOLATES ANY REQUIRED DISCLOSURE OF INFORMATION, INCLUDING INTENTIONAL NON-DISCLOSURE, IS SUBJECT TO CIVIL MONEY PENALTY NOT TO EXCEED \$10,000 FOR EACH VIOLATION.

Thank you. If you have any questions, please contact the Legal Compliance Officer by email at 504ada@housingforhouston.com.