CITY OF WEST COVINA PLANNING DEPARTMENT

General Instructions
Reasonable Accommodation Applications

Please note which type of application you are applying for, and use both this packet and the appropriate specialized information packet as you prepare your application.

All of the following must be submitted before the Planning Department can process the application:

1. Application Sheet, with disability evidence from a doctor

2. Filing Fee and Deposit Agreement:

   a. Administrative Review: $770.00 deposit, plus $96.36 per hour of staff time.
      - *Any time required of the City Attorney will be billed at the attorney's current rate*

   b. Completed Deposit Agreement, as attached to this packet

   ***NOTE**: Building permits associated with this application will not be issued until all filing fees are collected and deposit accounts are settled.*

3. Site Plan: a. 3 prints (*required at time application is submitted)
   Prints to be folded to maximum 8½" x 13"

4. Floor Plan: a. 3 prints (*required at time application is submitted)
   Prints to be folded to maximum 8½" x 13"

5. Occupant's Permission to Enter Site: submit attached form with ink signature of occupant

6. Covenant (required after approval)

*Plans must be folded to maximum 8 ½" x 13". Plans must be folded and stapled together in sets.

It is the policy of the CITY OF WEST COVINA to provide reasonable accommodation to persons with disabilities in accordance with the requirements of the Federal and State Fair Housing Acts, the ordinances of the CITY OF WEST COVINA, and other legal requirements. **This form may be used by any individual or organization requesting reasonable accommodation from the application of a City ordinance, law, regulation or policy due to a disability**. Any such individual or organization must complete this form for processing.

SECTION 1: APPLICANT

A. NAME: _____

B. MAILING ADDRESS: _____

C. DAYTIME PHONE NUMBER: (_____) _____-_____ OTHER PHONE NUMBER: (_____) _____-_____

D. ADDRESS OF LOCATION WHERE REASONABLE ACCOMMODATION IS REQUESTED (hereinafter "THE LOCATION"): _____

_____

E. IS THERE A CITY OF WEST COVINA BUSINESS LICENSE FOR THE LOCATION?: ☐ **YES** ☐ **NO**

IF **YES**, PROVIDE LICENSE NUMBER: _____

SECTION 2: REQUEST (*CHECK ONE BOX ONLY*)

☐ **I AM REQUESTING REASONABLE ACCOMMODATION FOR MYSELF**

☐ **I AM REQUESTING REASONABLE ACCOMMODATION ON BEHALF OF ONE OR MORE DISABLED INDIVIDUALS**

☐ **I AM REQUESTING REASONABLE ACCOMMODATION FOR MYSELF AND ON BEHALF OF ONE OR MORE DISABLED INDIVIDUALS**

INFORMATION FOR ALL INDIVIDUALS FOR WHOM REASONABLE ACCOMMODATION IS REQUESTED MUST BE PROVIDED IN SECTION 4, OF THIS FORM, BELOW

PLEASE SUMMARIZE THE ACCOMMODATION THAT IS REQUESTED?: _____

_____

_____

_____

_____

SECTION 3: LOCATION

A. ARE SERVICES OTHER THAN HOUSING PROVIDED AT THE LOCATION?: ☐ **YES** ☐ **NO**

IF **YES**, PLEASE ANSWER THE FOLLOWING:

1. IS MEDICAL TREATMENT PROVIDED BY A DOCTOR OR HEALTH CARE PROVIDER AT THE LOCATION?: ☐ **YES** ☐ **NO**

   IF **YES**, PLEASE DESCRIBE ALL SUCH MEDICAL TREATMENT: _____

   _____

   _____

   _____

2. ARE DRUGS OR MEDICATION ADMINISTERED AT THE LOCATION, OR IS ASSISTANCE WITH TAKING MEDICTION PROVIDED AT THE LOCATION?: ☐ **YES** ☐ **NO**
3. IS THERE A CENTRAL POINT FOR STORAGE OR DISTRIBUTION OF DRUGS OR MEDIATION AT THE LOCATION?: ☐ **YES** ☐ **NO**
4. IS ASSISTANCE WITH ARRANGING MEDICAL OR DENTAL CARE PROVIDED AT THE LOCATION?: ☐ **YES** ☐ **NO**

   IF **YES**, PLEASE DESCRIBE THE TYPE AND SCOPE OF ASSISTANCE PROVIDED: _____

   _____

   _____

   _____

(***SECTION 3 CONTINUED ON NEXT PAGE***)

SECTION 3: LOCATION (*CONTINUED FROM PAGE 1*):

5. IS CONVALESCENT CARE PROVIDED AT THE LOCATION?: ☐ **YES** ☐ **NO**

   IF **YES**, PLEASE DESCRIBE THE TYPE AND SCOPE OF CONVALESCENT CARE PROVIDED:_____

6. IS HOSPICE CARE PROVIDED AT THE LOCATION?: ☐ **YES** ☐ **NO**

   IF **YES**, PLEASE DESCRIBE THE TYPE AND SCOPE OF HOSPICE CARE PROVIDED:_____

7. ARE PHYSICAL THERAPY OR REHABILITATION SERVICES PROVIDED AT THE LOCATION?: ☐ **YES** ☐ **NO**

   IF **YES**, PLEASE DESCRIBE ALL PHYSICAL THERAPY OR REAHBILITATION SERVICES PROVIDED:_____

8. ARE PSYCHOTHERAPY OR MENTAL HEALTH SERVICES PROVIDED AT THE LOCATION?: ☐ **YES** ☐ **NO**

   IF **YES**, PLEASE DESCRIBE ALL PSYCHOTHERAPY OR MENTAL HEALTH SERVICES PROVIDED:_____

9. IS DRUG, ALCOHOL, INDIVIDUAL, OR GROUP COUNSELING PROVIDED AT THE LOCATION?: ☐ **YES** ☐ **NO**

   IF **YES**, PLEASE DESCRIBE THE NATURE AND FORMAT OF COUNSELING PROVIDED:_____

10. IS ASSISTANCE IN DRESSING, GROOMING, BATHING OR PERSONAL HYGIENE PROVIDED AT THE LOCATION?: ☐ **YES** ☐ **NO**

11. ARE RESIDENTS' SCHEDULES OR ACTIVIES SUPERVISED BY OWNERS OR OPERATORS OF THE LOCATION?: ☐ **YES** ☐ **NO**

12. DO OWNERS OR OPERATORS OF THE LOCATION MONITOR, CONTROL OR HAVE RESPONSIBILITY OVER THE BEHAVIOR OR ACTIVITIES OF DISABLED INDIVIDUAL(S) AT THE LOCATION?: ☐ **YES** ☐ **NO**

    IF **YES**, PLEASE DESCRIBE ALL SUCH MONITORING, CONTROL, AND/OR RESPONSIBILITIES:_____

13. ARE RESIDENTS' MONEY, FINANCES, OR PROPERTY SUPERVISED OR MANAGED BY OWNERS OR OPERATORS OF THE LOCATION?: ☐ **YES** ☐ **NO**

    IF **YES**, PLEASE DESCRIBE ALL SUCH SUPERVISION OR MANAGEMENT:_____

14. ARE RESIDENTS' FOOD INTAKE, NUTRITIONAL SUPPLEMENTS, OR DIETS SUPERVISED OR MANAGED BY OWNERS OR OPERATORS OF THE LOCATION?: ☐ **YES** ☐ **NO**

    IF **YES**, PLEASE DESCRIBE THE NATURE OF ALL SUCH SUPERVISION OR MANAGEMENT:_____

15. PLEASE DESCRIBE ALL OTHER SERVICES PROVIDED AT THE LOCATION:_____

B. ARE ANY LICENSE(S) OR PERMIT(S) ISSUED BY THE STATE OF CALIFORNIA FOR HOUSING AND/OR SERVICES PROVIDED AT THE LOCATION? : ☐ **YES** ☐ **NO**

   IF **YES**, PLEASE ATTACH COPIES OF ALL LICENSES AND PERMITS ISSUED FOR THE LOCATION

   IN ADDITION, PLEASE LIST ALL LICENSES AND PERMITS:_____

SECTION 4: DISABILITY

THE FOLLOWING INFORMATION IS REQUIRED FOR EACH INDIVIDUAL FOR WHOM REASONABLE ACCOMMODATION IS REQUESTED (INCLUDING THE APPLICANT, IF APPLICABLE). **PLEASE FILL-IN THE FOLLOWING INFORMATION FOR EACH INDIVIDUAL FOR WHOM REASONABLE ACCOMMODATION IS REQUESTED** (*LIST ADDITIONAL INDIVIDUALS ON THE* ***SECTION 4 – SUPPLEMENT FORM***):

NAME:_____
ADDRESS:_____
CITY/STATE:_____
ZIP CODE:_____
PHONE NUMBER:_____

LIST ALL DISABILITIES WHICH REQUIRE REASONABLE ACCOMMODATION:

1ST DISABILITY:_____

HAS THIS DISABILITY BEEN DIAGNOSED?: □ **YES** □ **NO**

IF **YES**, PLEASE PROVIDE THE NAME, OFFICE, ADDRESS, AND PHONE NUMBER OF THE DOCTOR OR HEALTH PROFESSIONAL WHO MADE THE DIAGNOSIS:

NAME:_____
OFFICE:_____
ADDRESS:_____
CITY/STATE:_____
ZIP CODE:_____
PHONE NO.:_____

2ND DISABILITY:_____

HAS THIS DISABILITY BEEN DIAGNOSED?: □ **YES** □ **NO**

IF **YES**, PLEASE PROVIDE THE FOLLOWING FOR THE DOCTOR OR HEALTH PROFESSIONAL WHO MADE THE DIAGNOSIS:

NAME:_____
OFFICE:_____
ADDRESS:_____
CITY/STATE:_____
ZIP CODE:_____
PHONE NO.:_____

PLEASE LIST ANY ADDITIONAL DISABILITIES ON SEPARATE PAGES

HOW DO THE DISABILITIES LISTED ABOVE AFFECT DAILY LIFE (*SUCH AS MOBILITY, LIVELIHOOD, EMPLOYMENT, PERSONAL CARE, COMMUNICATION, ETC.)*:_____
_____
_____
_____
_____

ARE THE DISABILITIES MONITORED OR SUPERVISED BY A DOCTOR OR HEALTH CARE PROFESSIONAL?: □ **YES** □ **NO**

ARE THE DISABILITIES CURRENTLY ADDRESSED THROUGH MEDICAL TREATMENT, THERAPY, SUPPORT, OR OTHER MEDICAL CARE?: □ **YES** □ **NO**

IF **YES**, PLEASE DESCRIBE:_____
_____
_____
_____
_____

NAME:_____
ADDRESS:_____
CITY/STATE:_____
ZIP CODE:_____
PHONE NUMBER:_____

LIST ALL DISABILITIES WHICH REQUIRE REASONABLE ACCOMMODATION:

1ST DISABILITY:_____

HAS THIS DISABILITY BEEN DIAGNOSED?: □ **YES** □ **NO**

IF **YES**, PLEASE PROVIDE THE NAME, OFFICE, ADDRESS, AND PHONE NUMBER OF THE DOCTOR OR HEALTH PROFESSIONAL WHO MADE THE DIAGNOSIS:

NAME:_____
OFFICE:_____
ADDRESS:_____
CITY/STATE:_____
ZIP CODE:_____
PHONE NO.:_____

2ND DISABILITY:_____

HAS THIS DISABILITY BEEN DIAGNOSED?: □ **YES** □ **NO**

IF **YES**, PLEASE PROVIDE THE FOLLOWING FOR THE DOCTOR OR HEALTH PROFESSIONAL WHO MADE THE DIAGNOSIS:

NAME:_____
OFFICE:_____
ADDRESS:_____
CITY/STATE:_____
ZIP CODE:_____
PHONE NO.:_____

PLEASE LIST ANY ADDITIONAL DISABILITIES ON SEPARATE PAGES

HOW DO THE DISABILITIES LISTED ABOVE AFFECT DAILY LIFE (*SUCH AS MOBILITY, LIVELIHOOD, EMPLOYMENT, PERSONAL CARE, COMMUNICATION, ETC.)*:_____
_____
_____
_____
_____

ARE THE DISABILITIES MONITORED OR SUPERVISED BY A DOCTOR OR HEALTH CARE PROFESSIONAL?: □ **YES** □ **NO**

ARE THE DISABILITIES CURRENTLY ADDRESSED THROUGH MEDICAL TREATMENT, THERAPY, SUPPORT, OR OTHER MEDICAL CARE?: □ **YES** □ **NO**

IF **YES**, PLEASE DESCRIBE:_____
_____
_____
_____
_____

NAME:_____
ADDRESS:_____
CITY/STATE:_____
ZIP CODE:_____
PHONE NUMBER:_____

LIST ALL DISABILITIES WHICH REQUIRE REASONABLE ACCOMMODATION:

1ST DISABILITY:_____

HAS THIS DISABILITY BEEN DIAGNOSED?: □ **YES** □ **NO**

IF **YES**, PLEASE PROVIDE THE NAME, OFFICE, ADDRESS, AND PHONE NUMBER OF THE DOCTOR OR HEALTH PROFESSIONAL WHO MADE THE DIAGNOSIS:

NAME:_____
OFFICE:_____
ADDRESS:_____
CITY/STATE:_____
ZIP CODE:_____
PHONE NO.:_____

2ND DISABILITY:_____

HAS THIS DISABILITY BEEN DIAGNOSED?: □ **YES** □ **NO**

IF **YES**, PLEASE PROVIDE THE FOLLOWING FOR THE DOCTOR OR HEALTH PROFESSIONAL WHO MADE THE DIAGNOSIS:

NAME:_____
OFFICE:_____
ADDRESS:_____
CITY/STATE:_____
ZIP CODE:_____
PHONE NO.:_____

PLEASE LIST ANY ADDITIONAL DISABILITIES ON SEPARATE PAGES

HOW DO THE DISABILITIES LISTED ABOVE AFFECT DAILY LIFE (*SUCH AS MOBILITY, LIVELIHOOD, EMPLOYMENT, PERSONAL CARE, COMMUNICATION, ETC.)*:_____
_____
_____
_____
_____

ARE THE DISABILITIES MONITORED OR SUPERVISED BY A DOCTOR OR HEALTH CARE PROFESSIONAL?: □ **YES** □ **NO**

ARE THE DISABILITIES CURRENTLY ADDRESSED THROUGH MEDICAL TREATMENT, THERAPY, SUPPORT, OR OTHER MEDICAL CARE?: □ **YES** □ **NO**

IF **YES**, PLEASE DESCRIBE:_____
_____
_____
_____
_____

NOTE: ANY ADDITIONAL INDIVIDUALS FOR WHOM REASONABLE ACCOMMODATION IS REQUESTED SHOULD BE IDENTIFIED ON THE *SECTION 4 – SUPPLEMENT FORM* AND ATTACHED TO THIS APPLICATION

SECTION 5: ACCOMMODATION

A. WHAT ACCOMMODATIONS ARE YOU REQUESTING? (*PROVIDE ALL ACCOMMODATIONS THAT ARE REQUESTED FOR ALL INDIVIDUALS IDENTIFIED IN **SECTION 4**, ABOVE, INCLUDING THOSE LISTED ON THE **SECTION 4 – SUPPLEMENT FORM***):_____
_____
_____
_____

B. DOES ANY CITY ORDINANCE, LAW, REGULATION OR POLICY PREVENT DISABLED INDIVIDUALS FROM RESIDING AT THE

LOCATION IDENTIFIED IN **SECTION 1.D**, ABOVE?: ☐ **YES** ☐ **NO**

C. DOES ANY CITY ORDINANCE, LAW, REGULATION OR POLICY OBSTRUCT OR IMPEDE DISABLED INDIVIDUALS' USE OF THAT LOCATION AS HOUSING?: ☐ **YES** ☐ **NO**

IF THE RESPONSE TO *EITHER* **SECTION 5.B.** OR **SECTION 5.C.** IS **YES**, PLEASE ANSWER THE FOLLOWING:

1. WHAT ORDINANCE, LAW, REGULATION OR POLICY PREVENTS DISABLED INDIVIDUALS FROM RESIDING AT, OR SECURING HOUSING AT, THE LOCATION? (*INCLUDE CODE SECTION AND/OR ORDINANCE NUMBER IF KNOWN*):_____
2. HOW DOES THE ORDINANCE, LAW, REGULATION, OR POLICY PREVENT, OBSTRUCT, OR IMPEDE DISABLED INDIVIDUALS FROM RESIDING AT, OR SECURING HOUSING AT, THAT LOCATION?:_____
3. HOW CAN THE ORDINANCE, LAW, REGULATION OR POLICY BE CHANGED SO THAT IT DOES NOT PREVENT DISABLED INDIVIDUALS FROM RESIDING AT THAT LOCATION, OR SO THAT IT DOES NOT OBSTRUCT OR IMPEDE THEIR ABILITY TO USE THAT LOCATION FOR HOUSING?:_____

D. DOES RESIDING AT THE LOCATION ASSIST IN THE TREATMENT OF, OR RECOVERY FROM, THE DISABILITIES IDENTIFIED IN **SECTION 4**, ABOVE?: ☐ **YES** ☐ **NO**

IF **YES**, PLEASE ANSWER THE FOLLOWING (*PROVIDE FOR EACH INDIVIDUAL FOR WHOM REASONABLE ACCOMMODATION IS REQUESTED; LIST ON SEPARATE PAGE IF NECESSARY*):

1. WHAT FEATURES, CHARACTERISTICS OR ATTRIBUTES OF THE LOCATION ASSIST WITH TREATMENT OR RECOVERY?:_____
2. HOW WILL RESIDING AT THE LOCATION ASSIST IN THE TREATMENT OF, OR RECOVERY FROM, THE DISABILITIES?:_____

E. HAS A DOCTOR OR HEALTH CARE PROFESSIONAL INDICATED THAT RESIDING AT THIS LOCATION WILL ASSIST IN THE TREATMENT OF, OR RECOVERY FROM, THE DISABILITIES IDENTIFIED IN **SECTION 4**, ABOVE?: ☐ **YES** ☐ **NO**

SECTION 6: CONSENT FOR RESIDENCY

THE CITY OF WEST COVINA MUST VERIFY THAT THE OWNER, TENANT, OR LAWFUL OCCUPANT OF THE LOCATION CONSENTS TO HAVING ALL IDENTIFIED INDIVIDUALS RESIDE AT THE LOCATION. *PLEASE CHECK THE APPROPRIATE BOX AND PROVIDE THE REQUIRED SIGNATURES BELOW*:

☐ **I/WE AM/ARE THE OWNER(S) OF THE LOCATION IDENTIFIED IN *SECTION 1.D.*, ABOVE, AND I/WE CONSENT TO HAVING ALL INDIVIDUALS IDENTIFIED IN *SECTION 4* (INCLUDING *SECTION 4 – SUPPLEMENT FORM*) RESIDE AT THE LOCATION.**

NAME (OWNER):_____ SIGNATURE:_____ DATE:_____

NAME (CO-OWNER):_____ SIGNATURE:_____ DATE:_____

☐ **I/WE AM/ARE A TENANT(S) AT THE LOCATION IDENTIFIED IN *SECTION 1.D.*, ABOVE, I/WE CONSENT TO HAVING ALL INDIVIDUALS IDENTIFIED IN *SECTION 4* (INCLUDING *SECTION 4 – SUPPLEMENT FORM*) RESIDE AT THE LOCATION, AND SUCH RESIDENCY IS PERMITTED ACCORDING TO THE TERMS OF MY/OUR LEASE.**

NAME (LESSEE):_____ SIGNATURE:_____ DATE:_____

NAME (CO-LESSEE):_____ SIGNATURE:_____ DATE:_____

☐ **I AM NEITHER THE OWNER NOR A TENANT AT THE LOCATION IDENTIFIED IN *SECTION 1.D.*, ABOVE, BUT I AM A LAWFUL OCCUPANT OF THE LOCATION AND I CONSENT TO HAVING ALL INDIVIDUALS IDENTIFIED IN *SECTION 4* (INCLUDING *SECTION 4 – SUPPLEMENT FORM*) RESIDE AT THE LOCATION.**

NAME (OCCUPANT):_____ SIGNATURE:_____ DATE:_____

SECTION 7: PHYSICAL CHARACTERISTICS, CONFIGURATION, AND OCCUPANCY

PLEASE PROVIDE THE FOLLOWING INFORMATION ON PHYSICAL CHARACTERISTICS AND CONFIGURATION OF THE LOCATION FOR WHICH REASONABLE ACCOMMODATION IS REQUESTED (*LIST ON SEPARATE PAGES IF NECESSARY*):

A. LIST THE SQUARE FOOTAGE OR DIMENSIONS OF THE FOLLOWING:

1. THE LOCATION (PARCEL OR LOT) WHERE REASONABLE ACCOMMODATION IS REQUESTED:_____
2. THE BUILDING (STRUCTURE) WHERE REASONABLE ACCOMMODATION IS REQUESTED:_____

B. LIST THE TOTAL NUMBER OF ROOMS IN THE BUILDING WHERE REASONABLE ACCOMMODATION IS REQUESTED (INCLUDING

LIVING ROOMS, BEDROOMS, KITCHENS, BATHROOMS, DINING ROOMS, STORAGE ROOMS, AND ALL OTHER ENCLOSED OR SEPARATED LIVING AREAS WITHIN THE BUILDING):_____ **PLEASE IDENTIFY THE ROOMS AS FOLLOWS:**

1. TOTAL NUMBER OF **KITCHENS** OR ROOMS WHERE FOOD IS PREPARED:_____
2. TOTAL NUMBER OF **BEDROOMS** OR ROOMS WHERE INDIVIDUALS SLEEP:_____
3. TOTAL NUMBER OF **BATHROOMS** OR ROOMS WHERE TOILETS, BATHTUBS, AND/OR SHOWERS ARE LOCATED::_____
4. TOTAL NUMBER OF **LIVING ROOMS**, **FAMILY ROOMS**, **DINING ROOMS**, AND OTHER ENCLOSED COMMON AREAS:_____
5. TOTAL NUMBER OF **STORAGE ROOMS**, **UTILITY ROOMS**, **WALK-IN CLOSETS**, AND ENCLOSED STORAGE AREAS:_____
6. TOTAL NUMBER OF **ATTACHED GARAGES**:_____

C. HOW MANY INDIVIDUALS CURRENTLY RESIDE AT THE BUILDING WHERE REASONABLE ACCOMMODATION IS REQUESTED?:_____

D. HOW MANY INDIVIDUALS WILL RESIDE AT THE BUILDING IF REASONABLE ACCOMMODATION IS GRANTED?:_____

E. DOES THE OWNER, TENANT, OR LAWFUL OCCUPANT IDENTIFIED IN **SECTION 6**, ABOVE, CONSENT TO AN INSPECTION OF THE LOCATION AT A REASONABLE TIME AS PART OF ITS EVALUATION OF THE REQUEST FOR REASONABLE ACCOMMODATION? (*THE ANSWER TO THIS QUESTION WILL NOT AFFECT THE CITY'S EVALUATION OF THE REQUEST*): ☐ **YES** ☐ **NO**

IF **YES**, PLEASE PROVIDE CONSENT FOR THE INSPECTION BY PROVIDING THE REQUIRED SIGNATURES, BELOW:

I AM AN OWNER, TENANT, OR LAWFUL OCCUPANT IDENTIFIED IN *SECTION 6*, ABOVE, AND I HEREBY CONSENT TO THE CITY OF WEST COVINA'S ENTRY ON TO AND INSPECTION OF THE LOCATION FOR PURPOSES OF EVALUATING THIS REQUEST FOR REASONABLE ACCOMMODATION.

NAME:_____ SIGNATURE:_____ DATE:_____

WHILE NOT REQUIRED FOR PROCESSING THE REQUEST FOR REASONABLE ACCOMMODATION REQUEST, PHOTOGRAPHS, PLANS, DIAGRAMS, AND OTHER MATERIALS INDICATING PHYSICAL CHARACTERISTICS AND CONFIGURATION OF THE LOCATION AND BUILDING WHERE REASONABLE ACCOMMODATION IS REQUESTED MAY BE OF ASSISTANCE TO THE CITY OF WEST COVINA IN PROCESSING THIS REQUEST. **PLEASE ATTACH TO THIS APPLICATION COPIES OF RELEVANT MATERIALS WHICH YOU BELIEVE WILL BE OF SUCH ASSISTANCE**.

SECTION 8: VERIFICATION AND AUTHORIZATION

IT MAY BE NECESSARY FOR THE CITY OF WEST COVINA TO VERIFY THE DISABILITIES WHICH NECESSITATE THE REQUEST FOR REASONABLE ACCOMMODATION BY CONTACTING THE DOCTOR OR HEALTH CARE PROFESSIONAL IDENTIFIED IN **SECTION 4**, ABOVE. COPIES OF THE CITY OF WEST COVINA'S ***REASONABLE ACCOMMODATION VERIFICATION FORM***, SIGNED BY EACH INDIVIDUAL IDENTIFIED IN **SECTION 4** (INCLUDING **SECTION 4 – SUPPLEMENT FORM**), SHOULD BE PROVIDED. **ALL PERSONAL HEALTH INFORMATION OBTAINED BY THE CITY OF WEST COVINA WILL BE KEPT CONFIDENTIAL AND USED SOLELY TO DETERMINE IF REASONABLE ACCOMMODATION SHOULD BE PROVIDED.**

HAVE ALL INDIVIDUALS FOR WHOM REASONABLE ACCOMMODATION IS REQUESTED SIGNED THE CITY OF WEST COVINA'S ***REASONABLE ACCOMMODATION VERIFICATION FORM***?: ☐ **YES** ☐ **NO**

- IF **YES**, PLEASE ATTACH ALL SIGNED FORMS (WITH ORIGINAL SIGNATURES) TO THIS REQUEST.
- IF **NO**, PLEASE BE ADVISED *THAT* ***ALTERNATE MEANS OF VERIFYING THE DISABILITY(IES) MAY BE NECESSARY***, AND THE CITY OF WEST COVINA MAY BE UNABLE TO REVIEW THE REQUEST FOR REASONABLE ACCOMMODATION UNTIL VERIFICATION HAS BEEN SATISFACTORILY COMPLETED.

I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT, TO THE BEST OF MY KNOWLEDGE, ALL INFORMATION PROVIDED ON THIS FORM IS TRUE AND CORRECT.

_____	_____	_____	_____
NAME **(printed or typed)**	TITLE **(for organization)**	SIGNATURE **(signed)**	DATE

WHEN COMPLETED, PLEASE RETURN THIS FORM AND ALL ATTACHMENTS TO THE CITY OF WEST COVINA PLANNING DEPARTMENT LOCATED AT: 1444 W. GARVEY AVE. SO., WEST COVINA, CA 91790

CITY OF WEST COVINA
1444 W. GARVEY AVENUE SO.
WEST COVINA, CA 91790

REASONABLE ACCOMMODATION VERIFICATION FORM

The CITY OF WEST COVINA provides reasonable accommodation to persons with disabilities in accordance with the requirements of the Federal and State Fair Housing Acts, City ordinances, and other legal requirements. **The individual on this form identifies him or herself as being disabled and has requested an adjustment in the application of a City ordinance, law, regulation or policy in order to accommodate his or her disability**. The CITY OF WEST COVINA grants reasonable accommodation requests based, in part, upon verification of the disability by the individual's doctor or licensed health care provider. **The authorization below permits the disclosure of information to the CITY OF WEST COVINA for purposes of verifying the disability and determining the need for reasonable accommodation**.

SECTION 1: AUTHORIZATION AND CONSENT TO DISCLOSE INFORMATION (*TO BE COMPLETED BY INDIVIDUAL FOR WHOM REASONABLE ACCOMMODATION IS REQUESTED*)

AUTHORIZATION AND CONSENT TO RELEASE INFORMATION: This form provides consent and authorization for your doctor or health care provider to disclose relevant information to CITY OF WEST COVINA regarding your need for reasonable accommodation. Information disclosed to the City will be kept confidential, unless redisclosure is required by law or required for legal proceedings. INFORMATION USED OR DISCLOSED PURSUANT TO YOUR AUTHORIZATION MAY BE SUBJECT TO REDISCLOSURE BY THE CITY OF WEST COVINA AND NO LONGER BE PROTECTED BY PRIVACY RULES. **BY SIGNING THIS FORM, YOU GRANT YOUR CONSENT TO YOUR DOCTOR OR HEALTH CARE PROVIDER TO RELEASE THE REQUESTED INFORMATION TO THE CITY OF WEST COVINA**.

I, _____, hereby REQUEST or AUTHORIZE the doctor or health
(PRINTED NAME OF APPLICANT OR PATIENT)
care professional listed in **Section 2** to disclose information described in **Section 3** within 60 days of signing this form to the CITY OF WEST COVINA Planning Manager for purposes of verifying my need for reasonable accommodation and other services at

the following location _____.
(PRINT LOCATION WHERE REASONABLE ACCOMMODATION IS REQUESTED)

This consent is subject to revocation at any time except to the extent that the program which is to make the disclosure has already taken action in reliance on it. If not previously revoked, this consent will terminate upon the CITY OF WEST COVINA's final determination of your request for reasonable accommodation.

You have a right to receive a copy of this form.

_____	_____	_____
SIGNATURE OF APPLICANT/PATIENT (OR PARENT/GUARDIAN, WHERE REQUIRED)	SIGNATURE OF PARENT OR GUARDIAN (WHERE REQUIRED)	DATE
_____	_____	_____
SIGNATURE OF REPRESENTATIVE (AUTHORIZED SIGNATOR, WHERE REQUIRED)	AUTHORITY OF REPRESENTATIVE (e.g., TITLE OR AUTHORIZATION, WHERE REQUIRED)	DATE

PLEASE PROVIDE INFORMATION CONCERNING YOUR DOCTOR OR HEALTH CARE PROFESSIONAL IN *SECTION 2* ON THE FOLLOWING PAGE

SECTION 2: DOCTOR OR HEALTH CARE PROFESSIONAL INFORMATION (*TO BE COMPLETED BY INDIVIDUAL FOR WHOM REASONABLE ACCOMMODATION IS REQUESTED*)

PLEASE PROVIDE THE FOLLOWING INFORMATION CONCERNING YOUR DOCTOR OR HEALTH CARE PROFESSIONAL:

- DOCTOR/PROFESSIONAL NAME:_____
- OFFICE OR FACILITY NAME:_____
- ADDRESS:_____
- PHONE NUMBER:_____ FAX NUMBER:_____

SECTION 3: DISABILITY EVALUATION (*TO BE COMPLETED BY DOCTOR OR HEALTH CARE PROFESSIONAL WITHIN 60-DAYS OF THE DATE LISTED IN **SECTION 1***)

PLEASE PROVIDE THE FOLLOWING INFORMATION:

- NAME OF INDIVIDUAL SIGNING **SECTION 4** OF THIS FORM:_____
- LICENSE, DEGREE, OR CERTIFICATION:_____
- LICENSE NUMBER:_____
- ADDRESS (if different from above):_____
- PHONE NO. (if different from above):_____ FAX NO. (if different from above):_____

IS THE INDIVIDUAL IDENTIFIED IN **SECTION 1** YOUR PATIENT, OR HAVE YOU PROVIDED MEDICAL TREATMENT, THERAPY, SUPPORT, OR MEDICAL CARE TO THAT INDIVIDUAL?: □ **YES** □ **NO**

DOES THAT INDIVIDUAL HAVE ONE OR MORE DISABILITIES? (*A DISABILITY IS ANY PHYSICAL OR MENTAL IMPAIRMENT WHICH SUBSTANTIALLY LIMITS ONE OR MORE LIFE ACTIVITIES*): □ **YES** □ **NO**

IF **YES**, PLEASE ANSWER THE FOLLOWING QUESTIONS REGARDING THE INDIVIDUAL:

A. WHAT ARE THE DISABILITIES? (*PLEASE LIST ALL DISABILITIES*):_____

_____

_____

B. ARE ANY SPECIAL LIVING ARRANGEMENTS NEEDED TO TREAT OR ACCOMMODATE THE DISABILITIES?: □ **YES** □ **NO**

IF **YES**, WHAT SPECIAL LIVING ARRANGEMENTS ARE NEEDED, AND WHY ARE THEY NEEDED?:_____

_____

_____

C. WHAT CONSEQUENCES WILL THIS INDIVIDUAL FACE IF THE LIVING ARRANGEMENTS ARE **NOT** MET?:_____

SECTION 4: VERIFICATION (*TO BE COMPLETED BY DOCTOR OR HEALTH CARE PROFESSIONAL*)

WARNING: Any person who signs this form and who willingly states as true any matter which he or she knows to be false is subject to penalty of perjury under Section 118 of the California Penal Code.

I CERTIFY THAT I AM THE TREATING PHYSICIAN AND/OR HEALTH CARE PROFESSIONAL FOR THE INDIVIDUAL LISTED IN **SECTION 1** OF THIS FORM ABOVE, AND ALL INFORMATION PROVIDED BY ME IS TRUTHFUL AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

NAME (printed)	TITLE (printed)	SIGNATURE (signed)	DATE
_____	_____	_____	_____

CITY OF WEST COVINA PLANNING DEPARTMENT

SECTION 4 – SUPPLEMENT FORM

PLEASE FILL-IN THE FOLLOWING INFORMATION FOR EACH INDIVIDUAL FOR WHOM REASONABLE ACCOMMODATION IS REQUESTED (*OTHER THAN THOSE LISTED AT SECTION 4; USE MULTIPLE PAGES, IF NECESSARY*):

NAME:_____
ADDRESS:_____
CITY/STATE:_____
ZIP CODE:_____
PHONE NUMBER:_____

LIST ALL DISABILITIES WHICH REQUIRE REASONABLE ACCOMMODATION:

1ST DISABILITY:_____

HAS THIS DISABILITY BEEN DIAGNOSED?: ☐ **YES** ☐ **NO**

IF **YES**, PLEASE PROVIDE THE NAME, OFFICE, ADDRESS, AND PHONE NUMBER OF THE DOCTOR OR HEALTH PROFESSIONAL WHO MADE THE DIAGNOSIS:

NAME:_____
OFFICE:_____
ADDRESS:_____
CITY/STATE:_____
ZIP CODE:_____
PHONE NO.:_____

2ND DISABILITY:_____

HAS THIS DISABILITY BEEN DIAGNOSED?: ☐ **YES** ☐ **NO**

IF **YES**, PLEASE PROVIDE THE FOLLOWING FOR THE DOCTOR OR HEALTH PROFESSIONAL WHO MADE THE DIAGNOSIS:

NAME:_____
OFFICE:_____
ADDRESS:_____
CITY/STATE:_____
ZIP CODE:_____
PHONE NO.:_____

PLEASE LIST ANY ADDITIONAL DISABILITIES ON SEPARATE PAGES

HOW DO THE DISABILITIES LISTED ABOVE AFFECT DAILY LIFE (*SUCH AS MOBILITY, LIVELIHOOD, EMPLOYMENT, PERSONAL CARE, COMMUNICATION, ETC.)*:_____
_____
_____
_____
_____

ARE THE DISABILITIES MONITORED OR SUPERVISED BY A DOCTOR OR HEALTH CARE PROFESSIONAL?: ☐ **YES** ☐ **NO**

ARE THE DISABILITIES CURRENTLY ADDRESSED THROUGH MEDICAL TREATMENT, THERAPY, SUPPORT, OR OTHER MEDICAL CARE?: ☐ **YES** ☐ **NO**

IF **YES**, PLEASE DESCRIBE:_____
_____
_____
_____
_____

NAME:_____
ADDRESS:_____
CITY/STATE:_____
ZIP CODE:_____
PHONE NUMBER:_____

LIST ALL DISABILITIES WHICH REQUIRE REASONABLE ACCOMMODATION:

1ST DISABILITY:_____

HAS THIS DISABILITY BEEN DIAGNOSED?: ☐ **YES** ☐ **NO**

IF **YES**, PLEASE PROVIDE THE NAME, OFFICE, ADDRESS, AND PHONE NUMBER OF THE DOCTOR OR HEALTH PROFESSIONAL WHO MADE THE DIAGNOSIS:

NAME:_____
OFFICE:_____
ADDRESS:_____
CITY/STATE:_____
ZIP CODE:_____
PHONE NO.:_____

2ND DISABILITY:_____

HAS THIS DISABILITY BEEN DIAGNOSED?: ☐ **YES** ☐ **NO**

IF **YES**, PLEASE PROVIDE THE FOLLOWING FOR THE DOCTOR OR HEALTH PROFESSIONAL WHO MADE THE DIAGNOSIS:

NAME:_____
OFFICE:_____
ADDRESS:_____
CITY/STATE:_____
ZIP CODE:_____
PHONE NO.:_____

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ARE THE DISABILITIES CURRENTLY ADDRESSED THROUGH MEDICAL TREATMENT, THERAPY, SUPPORT, OR OTHER MEDICAL CARE?: ☐ **YES** ☐ **NO**

IF **YES**, PLEASE DESCRIBE:_____
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_____
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NAME:_____
ADDRESS:_____
CITY/STATE:_____
ZIP CODE:_____
PHONE NUMBER:_____

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1ST DISABILITY:_____

HAS THIS DISABILITY BEEN DIAGNOSED?: ☐ **YES** ☐ **NO**

IF **YES**, PLEASE PROVIDE THE NAME, OFFICE, ADDRESS, AND PHONE NUMBER OF THE DOCTOR OR HEALTH PROFESSIONAL WHO MADE THE DIAGNOSIS:

NAME:_____
OFFICE:_____
ADDRESS:_____
CITY/STATE:_____
ZIP CODE:_____
PHONE NO.:_____

2ND DISABILITY:_____

HAS THIS DISABILITY BEEN DIAGNOSED?: ☐ **YES** ☐ **NO**

IF **YES**, PLEASE PROVIDE THE FOLLOWING FOR THE DOCTOR OR HEALTH PROFESSIONAL WHO MADE THE DIAGNOSIS:

NAME:_____
OFFICE:_____
ADDRESS:_____
CITY/STATE:_____
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ARE THE DISABILITIES MONITORED OR SUPERVISED BY A DOCTOR OR HEALTH CARE PROFESSIONAL?: ☐ **YES** ☐ **NO**

ARE THE DISABILITIES CURRENTLY ADDRESSED THROUGH MEDICAL TREATMENT, THERAPY, SUPPORT, OR OTHER MEDICAL CARE?: ☐ **YES** ☐ **NO**

IF **YES**, PLEASE DESCRIBE:_____
_____
_____
_____
_____

(*CONTINUED FROM PAGE 1*)

PLEASE FILL-IN THE FOLLOWING INFORMATION FOR EACH INDIVIDUAL FOR WHOM REASONABLE ACCOMMODATION IS REQUESTED (*OTHER THAN THOSE LISTED AT SECTION 4; USE MULTIPLE PAGES, IF NECESSARY*):

NAME:_____
ADDRESS:_____
CITY/STATE:_____
ZIP CODE:_____
PHONE NUMBER:_____

LIST ALL DISABILITIES WHICH REQUIRE REASONABLE ACCOMMODATION:

1ST DISABILITY:_____

HAS THIS DISABILITY BEEN DIAGNOSED?: □ **YES** □ **NO**

IF **YES**, PLEASE PROVIDE THE NAME, OFFICE, ADDRESS, AND PHONE NUMBER OF THE DOCTOR OR HEALTH PROFESSIONAL WHO MADE THE DIAGNOSIS:

NAME:_____
OFFICE:_____
ADDRESS:_____
CITY/STATE:_____
ZIP CODE:_____
PHONE NO.:_____

2ND DISABILITY:_____

HAS THIS DISABILITY BEEN DIAGNOSED?: □ **YES** □ **NO**

IF **YES**, PLEASE PROVIDE THE FOLLOWING FOR THE DOCTOR OR HEALTH PROFESSIONAL WHO MADE THE DIAGNOSIS:

NAME:_____
OFFICE:_____
ADDRESS:_____
CITY/STATE:_____
ZIP CODE:_____
PHONE NO.:_____

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_____
_____

ARE THE DISABILITIES MONITORED OR SUPERVISED BY A DOCTOR OR HEALTH CARE PROFESSIONAL?: □ **YES** □ **NO**

ARE THE DISABILITIES CURRENTLY ADDRESSED THROUGH MEDICAL TREATMENT, THERAPY, SUPPORT, OR OTHER MEDICAL CARE?: □ **YES** □ **NO**

IF **YES**, PLEASE DESCRIBE:_____
_____
_____
_____
_____

NAME:_____
ADDRESS:_____
CITY/STATE:_____
ZIP CODE:_____
PHONE NUMBER:_____

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1ST DISABILITY:_____

HAS THIS DISABILITY BEEN DIAGNOSED?: □ **YES** □ **NO**

IF **YES**, PLEASE PROVIDE THE NAME, OFFICE, ADDRESS, AND PHONE NUMBER OF THE DOCTOR OR HEALTH PROFESSIONAL WHO MADE THE DIAGNOSIS:

NAME:_____
OFFICE:_____
ADDRESS:_____
CITY/STATE:_____
ZIP CODE:_____
PHONE NO.:_____

2ND DISABILITY:_____

HAS THIS DISABILITY BEEN DIAGNOSED?: □ **YES** □ **NO**

IF **YES**, PLEASE PROVIDE THE FOLLOWING FOR THE DOCTOR OR HEALTH PROFESSIONAL WHO MADE THE DIAGNOSIS:

NAME:_____
OFFICE:_____
ADDRESS:_____
CITY/STATE:_____
ZIP CODE:_____
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_____
_____
_____
_____

ARE THE DISABILITIES MONITORED OR SUPERVISED BY A DOCTOR OR HEALTH CARE PROFESSIONAL?: □ **YES** □ **NO**

ARE THE DISABILITIES CURRENTLY ADDRESSED THROUGH MEDICAL TREATMENT, THERAPY, SUPPORT, OR OTHER MEDICAL CARE?: □ **YES** □ **NO**

IF **YES**, PLEASE DESCRIBE:_____
_____
_____
_____
_____

NAME:_____
ADDRESS:_____
CITY/STATE:_____
ZIP CODE:_____
PHONE NUMBER:_____

LIST ALL DISABILITIES WHICH REQUIRE REASONABLE ACCOMMODATION:

1ST DISABILITY:_____

HAS THIS DISABILITY BEEN DIAGNOSED?: □ **YES** □ **NO**

IF **YES**, PLEASE PROVIDE THE NAME, OFFICE, ADDRESS, AND PHONE NUMBER OF THE DOCTOR OR HEALTH PROFESSIONAL WHO MADE THE DIAGNOSIS:

NAME:_____
OFFICE:_____
ADDRESS:_____
CITY/STATE:_____
ZIP CODE:_____
PHONE NO.:_____

2ND DISABILITY:_____

HAS THIS DISABILITY BEEN DIAGNOSED?: □ **YES** □ **NO**

IF **YES**, PLEASE PROVIDE THE FOLLOWING FOR THE DOCTOR OR HEALTH PROFESSIONAL WHO MADE THE DIAGNOSIS:

NAME:_____
OFFICE:_____
ADDRESS:_____
CITY/STATE:_____
ZIP CODE:_____
PHONE NO.:_____

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_____
_____
_____

ARE THE DISABILITIES MONITORED OR SUPERVISED BY A DOCTOR OR HEALTH CARE PROFESSIONAL?: □ **YES** □ **NO**

ARE THE DISABILITIES CURRENTLY ADDRESSED THROUGH MEDICAL TREATMENT, THERAPY, SUPPORT, OR OTHER MEDICAL CARE?: □ **YES** □ **NO**

IF **YES**, PLEASE DESCRIBE:_____
_____
_____
_____
_____

Deposit Agreement

Case _____

This is to certify that I, _____
(applicant)

understand that the $770.00 deposited at the time of the filing of this application is to be used to cover staff time at the hourly rate determined by City Council Resolution (rate changes effective July 1st of each year), which is currently $96.36 per hour, and any City Attorney time at current rates. Should my deposit be depleted at any time prior to the completion of the process, the process will be suspended until additional deposits, the amount of which shall be determined by the Planning Director, are made. Failure to provide additional funds within ten (10) days after notification of depletion shall be cause for withdrawal of this application. I also understand that prior to the issuance of any future building permit(s) associated with this application, all fees must be collected and deposit accounts settled.

Signed: _____

Date: _____

Occupant's Permission To Enter And Investigate Site

City of West Covina
Planning Department
1444 West Garvey Avenue
West Covina, CA 91790

I, _____ as _____
(owner or lessee)

and occupant of the property located at _____

_____,

do hereby authorize representatives of the City of West Covina to enter upon the above-mentioned property for inspection purposes related to my application for Reasonable Accommodation No. _____ _____.

This authorization terminates upon the final decision on the case, made either by the Planning Director, or Planning Commission of the City of West Covina.

I do / do not have a dog on the premises.
(circle one)

_____ _____
Signature Date

FILING A COVENANT

Should the Reasonable Accommoadtion Request be granted, a covenant must be recorded detailing the accommodation approved and indicating that the accommodations will sunset once the person(s) for whom the request have been made no longer live on the property. All changes made to the property under the reasonable accommodation must be restored at that point to comply with development standards.

THE FOLLOWING IS THE PROCEDURE FOR FILING A COVENANT:

1. BRING A COPY OF THE GRANT DEED AND ONE SET OF PLANS (SITE PLAN, FLOOR PLAN AND ELEVATION PLAN) TO PLANNING DEPARTMENT. (Covenant will be prepared by Planning Department). **THERE IS A FLAT FEE OF $90.00.**

2. THE PLANNING DEPARTMENT WILL CONTACT YOU TO PICK UP COVENANT AND SUBMITTED PLANS IN PLANNING DEPARTMENT. (You may pick it up in the Planning Department or it may be mailed to you).

3. TAKE COVENANT TO A NOTARY PUBLIC AND HAVE YOUR PROPERTY OWNER SIGNATURE NOTARIZED. (Notary will notarize that you are the owner of property as listed in Covenant letter)

4. TAKE THE NOTARIZED COVENANT TO THE COUNTY RECORDER AND HAVE IT RECORDED. REQUEST A COPY OF THE RECORDED COVENANT. (There is a minimal fee for requesting a certified copy)

   COUNTY RECORDER'S ADDRESS IS:

   Los Angeles County Recorder
   12400 Imperial Highway
   Norwalk, CA 90650
   (562)462-2137

5. BRING COPY OF RECORDED COVENANT ALONG WITH THREE SETS OF PLANS BACK TO PLANNING DEPARTMENT. (County Recorder's Office will mail the original Recorded Covenant to the Planning Department within 6 to 8 weeks.)