

Reasonable Accommodation Policy

The Federal Fair Housing Act and other state and local fair housing laws require that housing owners and managers provide reasonable accommodations for applicants and residents who have disabilities. Vandelay Group LLC (“Vandelay Group”), its employees, agents, and designees and Jeffrey Koenig, the owner and manager of Vandelay Group, are committed to granting reasonable accommodations when necessary to afford persons with disabilities an equal opportunity to use and enjoy a dwelling at any and all of his rental units.

Please check all items that apply and answer all questions. Vandelay Group will answer this request within 14 days of receiving the request.

Today’s Date: _____

1) I am (please check one):

_____ **The person who has a disability and is requesting an Assistance Animal.** If so, please go to section 2.

_____ **A person making a request on behalf of or assisting the person with a disability who needs an Assistance Animal.** If so, please fill out the information below:

Name of person filling out form: _____

Address: _____

Telephone number: _____

Relationship to person needing Assistance Animal: _____

2) Name of person with a disability for whom a reasonable accommodation is being requested:

Phone number: _____

Address: _____

Identify the species of animal for which you are making a reasonable accommodation request e.g., “dog,” “cat”:

Provide the name and physical description (breed, size, color, weight, any tag and/or license) of the animal for which you are making a reasonable accommodation request:

Signature of person making request

Date

Signature of person with disability

Date

Applicant Name: _____

TO BE COMPLETED BY THE STATUTORILY AUTHORIZED HEALTHCARE PROVIDER:

1. Please provide a statement verifying that the person has an impairment that substantially limits one or more of the person's major life activities.

2. Please state whether the animal is necessary for the person to have an equal opportunity to use and enjoy housing or alleviate one or more of the effects of the person's disability. If so, please explain how it helps.

Name: _____

Title: _____

Address: _____

Telephone: _____

☐ By checking this box, under Wis. Stat. §106.50(1m)(mx)1, I certify that I am licensed to practice in the state of Wisconsin.

Wisconsin License #: _____

☐ By checking this box, under Wis. Stat. §106.50(1m)(mx)2, I certify that I am acting within the scope of my license or certification.

Signature

Date

TO BE COMPLETED BY MANAGEMENT:

Form accepted by:

Signature

Date