NOTICE OF RIGHT TO REASONABLE ACCOMMODATION/MODIFICATION

If you have a disability and any of the following kinds of changes would help you live in the Hammocks community, use its facilities, or take part in programs on site, you can request the following kinds of changes:

- • A change in Association rules or procedures
- • A modification in your condominium unit
- • A change or repair to some other part of the buildings or grounds
- • A change in the way the Association communicates with you or gives you information.

If you can show that you have a disability, and if your request is reasonable, we will try to approve/make the changes you request.

If we reject your request, we will explain the reasons for doing so in writing.

To make a request, please fill out the attached Reasonable Accommodation/Modification Request Form and provide us with as much information as you can. We also recommend that you complete the Verification Form attached in this packet, which the Association has provided as a resource for you to use in discussing your need for a reasonable accommodation or modification with your health care provider. The Verification Form will expedite the application process and help the Association make a determination regarding your request for a reasonable accommodation or modification. Please note that the Verification Form does not require your health care provider to disclose the nature of your disability.

If you need help filling out the attached Request Form, or if you want to give us your request in some other way, we will help you do so.

We will give you an answer in ten (10) days, unless there is a problem getting the information we need or unless you agree to a longer time period. We will let you know if we need more information or verification from you, or if we need to speak with you about other ways to meet your needs.

REASONABLE ACCOMMODATION/MODIFICATION REQUEST FORM

Date: _____

The Hammocks Association, Inc.
PO Box 3215
Bald Head Island, NC 28461

Dear Hammocks Board of Directors:

My name is _____, and my address is _____. I have a disability that prevents me from _____. I am therefore requesting a reasonable accommodation* ☐ and/or modification* ☐ (check all that apply).

I have attached information about the accommodation(s) or modification(s) I need in order to compensate for my disability. I am asking for this accommodation and/or modification so that I can have full use and enjoyment of my unit at the Hammocks.

I understand that if my request requires physical alterations to the unit or property, such alterations will be made at my expense.

Please reply to my request in writing within ten (10) business days. If you have any questions about my request, please contact me.

Sincerely,

_____
(Signature)

*Modifications involve physical alterations to your condominium unit or the Association Common Area. Accommodations refer to procedural changes, such as changes in Association rules or policies.

VERIFICATION OF INFORMATION SUPPLIED BY APPLICANT FOR REASONABLE ACCOMMODATION/MODIFICATION

To: The Hammocks Community Association, Inc.
PO Box 3215
Bald Head Island, NC 28461

From: (Health Care Provider)
_____
_____
_____
_____

Your patient, named below, has applied for a reasonable accommodation or modification to live at the Hammocks. Please provide a description of the request for the accommodation:
_____
_____
_____

The U.S. Department of Housing and Urban Development ("HUD") requires the Hammocks to verify all information that is used in determining this person's eligibility for the reasonable accommodation or modification.

Your patient has requested the reasonable accommodation or modification as described above. A reasonable accommodation or modification is a change to a policy, practice, procedure, or a physical alteration to a property that would allow the person to live in the Hammocks, use its facilities, or take part in programs on site. To show a requested accommodation may be necessary, there must be an identifiable relationship, or nexus, between the requested accommodation and the individual's disability.

We ask your cooperation in providing the following information and returning it to the person listed at the top of the page. Your prompt return of this information will help to assure timely processing of the application.

Your patient has consented to the release of this information, as shown below:

RELEASE – I hereby authorize the release of the requested information. Information obtained under this consent is limited to information that is no older than 12 months.

_____ _____
HAMMOCKS APPLICANT SIGNATURE DATE

Under federal law, an individual is disabled if he or she has a physical or mental impairment that substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such impairment. The term physical or mental impairment includes, but is not limited to, such diseases and conditions as orthopedic, visual, speech, and hearing impairments, cerebral palsy, autism, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, Human Immunodeficiency Virus infection, mental retardation, emotional illness, drug addiction, and alcoholism. This definition does not include any individual

who is an alcohol or drug abuser whose current use of alcohol or drugs prevents the individual from participating in the housing program or activities, or whose participation, by reason of such current alcohol or drug abuse, would constitute a direct threat to property or safety of others (*See* 24 CFR 8.3, and HUD Handbook 4350.3REV-1).

After reviewing the above definition and describing the request your patient has made (above), please make a determination as to the necessity of this accommodation to afford him or her opportunity to use and enjoy our community, using the questionnaire below:

1. In your professional opinion, is the individual disabled as defined above? (NOTE: Please do not name or describe the type of disability the individual has when filling out this section. We do not need to know the nature or severity of the disability.)

   _____
   _____
   _____

2. In your professional opinion, does the individual require the accommodation described above?

   _____
   _____
   _____

3. Please explain the identifiable relationship between the requested accommodation and the individual's disability.

   _____
   _____
   _____

4. Please describe any other accommodation or modification that could meet the individual's needs in place of what the household member has requested. For example, if there is a less expensive way to help the individual cope with his or her disability, please detail it.

   _____
   _____
   _____

1. In your professional opinion, is the individual disabled as defined above? (NOTE: Please do not name or describe the type of disability the individual has when filling out this section. We do not need to know the nature or severity of the disability.)

_____
_____
_____

2. In your professional opinion, does the individual require the accommodation described above?

_____
_____
_____

3. Please explain the identifiable relationship between the requested accommodation and the individual's disability.

_____
_____
_____

4. Please describe any other accommodation or modification that could meet the individual's needs in place of what the household member has requested. For example, if there is a less expensive way to help the individual cope with his or her disability, please detail it.

_____
_____
_____

By signing below, you certify that, pursuant to 18 U.S. Code § 1001, the statements you have made are complete and accurate, and that, pursuant to 42 U.S. Code § 3604, the above-named individual has a qualifying disability, the symptoms of which will be alleviated by the requested accommodation or modification.

_____ _____

Name of Health Care Provider Phone Number

_____ _____

Signature Date

ND: 4824-6342-3068, v. 1