

## **DISABILITY SUPPLEMENTAL QUESTIONNAIRE (HOUSING CASES)**

**Palm Beach County Office of Equal Opportunity**  
**215 North Olive Avenue, Suite 130 --- West Palm Beach, FL 33401**  
**Telephone: (561) 355-4883 / FAX: (561) 355-4932 / TDD: (561) 355-1517**  
**<http://www.co.palm-beach.fl.us>**

In order to process and further investigate your complaint of housing discrimination, we need your help in answering each of the following questions. These questions relate to how they apply to you as a person who has a disability and who is filing a claim of discrimination under Palm Beach County's Fair Housing Ordinance and the Federal Fair Housing Act. (These questions also apply to a disabled person whom you may be assisting in filing a complaint, or if you are filing a complaint because you believe that you have been discriminated against because you are associated with a person who is disabled.)

If you do not understand any question or if you need assistance in preparing your response, please contact an OEO Intake Technician at (561) 355-4883.

NOTE: This document will be made available in an alternate format to any person who needs an accommodation. Requests for an alternate format document should be made to the Office of Equal Opportunity at the above telephone number.

### **PERSONAL INFORMATION:**

- 1. My name is:** \_\_\_\_\_  
(First) (Middle Name or Initial) (Last)
- 2. I reside at** \_\_\_\_\_  
**in the City of** \_\_\_\_\_ **County of** \_\_\_\_\_  
**State of** \_\_\_\_\_ **Zip Code** \_\_\_\_\_
- 3. My daytime telephone number, including the area code is:**  
\_\_\_\_\_
- 4. My evening telephone number, including the area code is:**  
\_\_\_\_\_

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**INFORMATION ABOUT YOUR DISABILITY:**

**Under the County's Fair Housing Ordinance and the Federal Fair Housing Act, a person is considered disabled if they meet one of the definitions listed below.**

**For each definition, please state whether or not you believe it applies to you or the person(s) that you are assisting in filing a complaint, or the person with whom you are associated.**

- 1. Do you (or the person you are assisting) have a physical or mental impairment?    Yes \_\_\_\_\_ No \_\_\_\_\_**
  
- 2. Describe the physical or mental impairment?**
  
  
  
  
  
  
  
  
  
  
- 3. As a result of a physical or mental impairment are you substantially limited in performing one or more major life activities? \_\_\_\_\_ Yes \_\_\_\_\_ No**
  
  
  
  
  
  
  
  
  
  
- 4. Which of the following major life activities does your disability impair?**

**[Note: Please check all boxes that apply.]**

- |  |  |
|--|--|
| <input type="checkbox"/> Seeing                  | <input type="checkbox"/> Reaching                |
| <input type="checkbox"/> Hearing                 | <input type="checkbox"/> Breathing               |
| <input type="checkbox"/> Speaking                | <input type="checkbox"/> Learning                |
| <input type="checkbox"/> Walking                 | <input type="checkbox"/> Sitting                 |
| <input type="checkbox"/> Taking care of oneself  | <input type="checkbox"/> Lifting                 |
| <input type="checkbox"/> Working                 | <input type="checkbox"/> Other? Please describe: |
| <input type="checkbox"/> Performing Manual Tasks | _____  |
| <input type="checkbox"/> Standing                | _____  |

5. If you are employed, what percentage (%) of your job requires the activity or activities that you have identified in answer to question #4, above?

Less than 10% \_\_\_\_\_

More than 10% but less than 33% \_\_\_\_\_

More than 33% but less than 50% \_\_\_\_\_

More than 50% \_\_\_\_\_

6. Is your disability permanent?

Yes \_\_\_\_\_ No \_\_\_\_\_

7. If you answered "No" to question 6, how long is your disability expected to persist?

8. Is there a record or a history of such physical or mental impairment which limits one or more major life activities? Yes \_\_\_\_\_ No \_\_\_\_\_

9. Do you believe that your housing provider (either your landlord, condominium association, homeowner's association, realtor, etc.) knows about your disability? Yes \_\_\_\_\_ No \_\_\_\_\_

10. Did you request that the housing provider make any accommodations in rules, policies or procedures, or make any modifications to your dwelling unit because of your disability? Yes \_\_\_\_\_ No \_\_\_\_\_

11. If you requested an accommodation, what was it? \_\_\_\_\_

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When did you make the request? \_\_\_\_\_

Was it a written or verbal request? \_\_\_\_\_

To whom did you make the request? \_\_\_\_\_

12. What was the response to your request for an accommodation or modification? \_\_\_\_\_

**13. Please provide copies of any medical (or social service agency) documentation which substantiates the existence of your disability and the extent to which you are limited in performing daily major life activities.**

**14. Additional comments, if any:**

**Under penalty of perjury, I declare that I have read the entire contents of this Questionnaire and that my answers and statements contained herein are true and correct.**

**Signed:** \_\_\_\_\_

\_\_\_\_\_  
**Printed Name:** \_\_\_\_\_

**Date Signed:** \_\_\_\_\_