DISABILITY SUPPLEMENTAL QUESTIONNAIRE (PUBLIC ACCOMMODATION CASES)

If you need assistance in completing this form, have difficulty completing any portions of this form due to incompatibility with adaptive technology, or you need the information in an alternative format, please contact us at:

Palm Beach County Office of Equal Opportunity
301 North Olive Avenue, 10th Floor – West Palm Beach, FL 33401
Telephone: (561) 355-4883 | FAX: (561) 355-4932 | TDD: (561) 355-1517
http://www.pbcgov.com/equalopportunity

In order to process and further investigate your complaint of places of public accommodation 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 person with a disability 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 Equal Opportunity Specialist 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 _____
   Last Name *First Name* *Middle Name or Initial*
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 _____
5. My email address is _____
   (**NOTE**: Under Florida law, email addresses are public records. Do not provide your email address if you do not want it released in response to a public records request.)

INFORMATION ABOUT YOUR DISABILITY

Under the County's Housing and Places of Public Accommodation Ordinance, 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. As a result of a physical or mental impairment, are you substantially limited in performing one or more major life activities?

   ☐ Yes ☐ No

3. Which of the following major life activities does your disability impair? *(Please check all boxes that apply.)*

☐ **Seeing**
☐ **Hearing**
☐ **Speaking**
☐ **Walking**
☐ **Taking care of oneself**
☐ **Working**
☐ **Performing manual tasks**
☐ **Standing**
☐ **Reaching**
☐ **Breathing**
☐ **Learning**
☐ **Sitting**
☐ **Lifting**
☐ **Other** *(Please describe)*

_____

_____

4. Is your disability permanent? ☐ Yes ☐ No

5. If you answered "No" to Question 4, how long is your disability expected to persist?_____

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

7. Do you believe that the business knows about your disability? ☐ Yes ☐ No If yes, why do you believe they know?

_____

_____

_____

8. Did you request that the business make any accommodations in rules, policies or procedures or make any modifications to your dwelling unit because of your disability? ☐ Yes ☐ No

9. 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? _____

10. What was the response to your request for an accommodation or modification? _____

11. Please provide copies of documentation (do ***not*** send medical records) which substantiates the existence of your disability and the extent to which you are limited in performing daily major life activities.

12. Additional comments, if any: **(DO NOT PROVIDE MEDICAL RECORDS!)**

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 _____

Palm Beach County