



# VERIFICATION FOR A REASONABLE ACCOMMODATION/MODIFICATION BY QUALIFIED INDIVIDUAL



DATE \_\_\_\_\_ PROPERTY NAME / NUMBER 275BC

RESIDENT / APPLICANT NAME \_\_\_\_\_

PREMISES ADDRESS \_\_\_\_\_

CHECK IF SUBMITTED BY AN APPLICANT AND LIST APPLICANT'S CURRENT ADDRESS:

\_\_\_\_\_

PHONE \_\_\_\_\_ EMAIL OR OTHER ELECTRONIC ADDRESS \_\_\_\_\_

Name of person requesting the accommodation/modification: \_\_\_\_\_

Owner/Agent: Name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Email \_\_\_\_\_

I, \_\_\_\_\_ (print name) hereby certify that I am a health care provider in practice pursuant to the laws of \_\_\_\_\_ (state) or other reliable, qualified person in a position to be able to verify the existence of a disability and disability-related needs.

My address, phone number and email are:

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Email \_\_\_\_\_

I have examined/treated \_\_\_\_\_ (name) ON \_\_\_\_\_ (date) OR am otherwise familiar with and can credibly attest to the above person's conditions and have determined that, in my opinion, he or she (check which applies):

- Qualifies as a person with a disability as defined by Federal/State law  
 Does not qualify as a person with a disability as defined by Federal/State law.

### DEFINITION OF DISABLED

Under federal law, an individual is disabled if he/she has a physical or mental impairment that substantially limits one or more major life activities; has a record of such an impairment; or is regarded as having such an impairment.

The term physical or mental impairment includes, but is not limited to, such diseases and conditions as orthopedic, visual, speech and hearing impediments, 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 currently using illegal drugs or is a current user of alcohol who poses a direct threat to property or safety [24 CFR 100.201].

I understand the person listed above has requested the following accommodation/modification:

\_\_\_\_\_  
 \_\_\_\_\_

Further, I hereby verify, in my opinion, that the person's request for the accommodation/modification (check which applies):

- Is related to his/her disability and is necessary in order to provide him or her with full and equal use and enjoyment of the rental unit.  
 Is NOT related to his/her disability and/or is NOT necessary in order to provide him or her with full and equal use and enjoyment of the rental unit.

Signature \_\_\_\_\_ Date \_\_\_\_\_

### CONSENT TO VERIFICATION

*If this letter has been sent by Owner/Agent directly to the health care provider or other reliable, qualified individual, the applicant/resident has voluntarily given his/her permission to obtain this written verification as follows:*

I hereby voluntarily give my permission for \_\_\_\_\_ (Owner/Agent's name) to obtain written verification from the following health care provider or other reliable, qualified individual party:

\_\_\_\_\_ (name) regarding my request for a reasonable accommodation/modification based on a disability.

I understand that I am not required to give permission for Owner/Agent to obtain the above verification and that I have the right to obtain the verification myself and present it to Owner/Agent. I certify that I am voluntarily consenting to Owner/Agent obtaining such verification on my behalf and that Owner/Agent did not force or in any way coerce me to sign this consent.

RESIDENT / APPLICANT NAME \_\_\_\_\_

RESIDENT / APPLICANT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_