**CERTIFICATION OF NEED FOR REASONABLE ACCOMMODATION**

**THIS FORM MUST BE COMPLETED BY A QUALIFIED MEDICAL, REHABILITATION, OR OTHER NONMEDICAL SERVICE AGENCY PROFESSIONAL WHOSE FUNCTION IS TO PROVIDE SERVICES TO PERSONS WITH DISABILITIES/ILLNESSES AND MAY VERIFY YOUR NEED FOR A REASONABLE ACCOMMODATION.**

**Head of Household: \_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Household Member Who Needs an Accommodation(s): \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Unit #: \_\_\_\_\_\_\_\_\_\_**

**Daytime Phone:** (\_\_\_\_)**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cellular Phone: (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

The above individual is applying for a reasonable accommodation under applicable federal and state law and is requesting that you, as their provider, fill out the following certification.

**1. In my professional opinion and assessment:**

 The Household Member has a disability based on one or both of the following legal definitions

(Please check each that applies):

□They have a physical or mental impairment that substantially limits one or more major life activities; or

□They have a record of having such an impairment.

□ The Household Member requesting the accommodation(s) does NOT have a

**2. How current is your knowledge of the Household Member’s disability?**

□I have met with this individual to discuss their disability within the last six months

□ The last time I met with this individual to discuss their disability was over six months ago

□ Other (please explain): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CHANGES TO RULES/POLICIES/PROCEDURES DUE TO DISABILITY**

□ I certify that the above individual needs a change in a policy or procedure as a result of their disability in order to enjoy an equal housing opportunity.

Please use the space below to explain what accommodation(s) the Household Member who had a disability needs and why it is required. Use additional paper if needed.

(Name) experiences a disability which manifests itself in the following manner:

(Name)’s disability effects their ability to comply with their lease obligations in the follow manner:

(Name) requires the following accommodation of: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ because the accommodation will allow them to fully access their housing/services and/or comply with their lease obligations in the following manner:

**CERTIFICATION: (Please Choose one)**

□ **I certify** that the enclosed request for changes to the unit or common area or to rules, policies and procedures is necessary for the Household Member who has a disability, as a result of their disability in order to have an equal housing opportunity.

**OR**

□ **I cannot certify** that the enclosed request is necessary for changes to the unit or common area or to rules, policies and procedures for the Household Member who has a disability, as a result of their disability in order to have equal housing opportunity.

**OR**

□ **I do not believe** the Household Member who has a disability needs a change to the unit or common area or to rules, policies or procedures, as a result of their disability in order to have an equal housing opportunity.

**OR**

□ **I certify that the identified** Household Member does not have a disability, therefore, does not need a change to the unit or common area or to rules, policies or procedures, as a result of a disability in order to have an equal housing opportunity.

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

Medical/Social Work Provider's Signature Date

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

Name (Please print clearly) Title of medical or Social Work Professional or Expert

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

Agency or Clinic, if applicable

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

Complete Address

(\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Fax