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