

REASONABLE ACCOMMODATION MODIFICATION REQUEST/VERIFICATION

DATE OF REQUEST _____ PROPERTY NAME/NUMBER _____

RESIDENT NAME _____ UNIT #: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP _____

DAYTIME PHONE _____ EVENING PHONE _____

Name of disabled person requesting the accommodation/modification _____

Please describe the accommodation/modification you are requesting:

Please describe why the accommodation/modification described above is necessary for you to fully enjoy your dwelling and/or common areas:

(if you require additional space please attach additional written information to this document)

HOUSEHOLD MEMBER RELEASE

Release: I hereby authorize my healthcare provider, or other qualified individual, to provide my landlord or its agents, information directly related to this request for a reasonable accommodation/modification.

Signature _____ Date _____

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 impairment; or is regarded as having a impairment.

The term physical or mental impairment includes, but is not limited to, such diseases and conditions as orthopedic, individual, speech and hearing impairments, 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 doesn't 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].

HEALTH CARE PROVIDER INFORMATION

To: Qualified Individual (e.g., counselor, social worker, doctor, rehabilitation center, service agency, self-help group, clinics).

I, _____, certify that _____
NAME OF QUALIFIED INDIVIDUAL (PLEASE PRINT) NAME OF PERSON REQUESTING ACCOMMODATION

is is not (**please check one**) disabled as that term defines above. I further certify that the requested accommodation/modification

is is not (**please check one**) necessary for the person requesting the accommodation/modification to fully enjoy his/her dwelling and/or common areas as any non-disabled person would.

Signature _____ Date _____

Professional Title _____ Daytime Phone _____

Address _____