

Verification of Status as a Person with a Disability

Housing Provider: _____

RE: Name of Tenant/Applicant/Guest Requesting Accommodation and/or Modification:

The tenant, guest, or applicant listed above has sought the reasonable accommodation and/or modification described in the attached Request for a Reasonable Accommodation and/or Modification form. State and federal laws require housing providers to make reasonable modifications and/or accommodations to either the dwelling or other parts of the housing community and/or to policies, procedures, services or regulations when such changes are not unduly burdensome and are necessary because of a disability of an applicant, a household member, or a guest, so that the applicant, household member or guest can have an equal opportunity to use and enjoy the housing and/or facilities.

Federal regulations under the Fair Housing Amendments Act, Section 504 of the Rehabilitation Act of 1973, and the Americans with Disabilities Act, define "disability" as:

- a physical or mental impairment that substantially limits one or more major life activities;
- a record of having such an impairment;
- being regarded as having such an impairment.

A physical or mental impairment includes:

- any physiological disorder or condition;
- cosmetic disfigurement;
- anatomical loss affecting one or more of the following body systems: neurological, musculoskeletal, special sense organs, respiratory, speech organs, cardiovascular, reproductive, digestive, genito-urinary, hemic and lymphatic, skin, and endocrine.
- Any mental or psychological disorder, such as cognitive delays, organic brain syndrome, emotional or mental illness, and/or learning disabilities.
- Drug addiction and alcoholism are covered by these provisions as are, for example, cancer, heart disease, HIV, AIDS, and some temporary disabilities (such as broken limbs or symptoms arising from pregnancy).

IMPORTANT: The medical/social service professional certifying the disability and need for an accommodation and/or modification **IS NOT** required to reveal the specific nature and/or severity of the individual's disability, NOR specific information about treatment.

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As a medical/social service professional with the knowledge necessary to make a determination, I am able to advise that

(name of client)

qualifies as an individual with a disability as defined above and that the following accommodation and/or modification is consistent with the needs associated with his/her disability.

Accommodation/Modification Requested:

Expected duration of disability: **LIFETIME**

Specify Length if Not Lifetime: _____

List major life activities that are limited by the disability:

How the accommodation/modification, if approved, will offset the limitations of the major life activities referenced above:

Signature of Medical Professional

Printed Name and Title

Phone Number: _____

Date: _____