CHANDLER arizona
Community of Innovation

Date: _____

SUBJECT: VERIFICATION OF DISABILITY FOR PURPOSE OF DETERMINING REASONABLE ACCOMMODATION/MODIFICATION NEEDS

Name of the Head of Household: _____

Name of person needing the accommodation: _____

Date of Birth: _____

Dear Provider:

The above-named individual has applied for housing assistance or is receiving federally subsidized housing assistance under a program of the U.S. Department of Housing and Urban Development (HUD). HUD requires our office to verify all information that is used in determining this person's eligibility for and/or level of benefits.

We are requesting verification that the applicant/tenant has a disability in order to determine whether a reasonable accommodation in the City of Chandler's rules, policies, practices, or services, and/or a reasonable modification of the leased premises or public/common use areas is necessary to provide the applicant/tenant equal access to, and enjoyment of, the City's housing, programs, activities, and services.

We appreciate your cooperation in providing the requested information. Your prompt return of this information will help to ensure the timely processing of the application for assistance and/or request for reasonable accommodation/modification. The applicant/tenant has authorized your release of the requested information and a copy of the signed authorization form is provided with this request.

Cordially,

Housing Specialist

Encl: Verification of Disability for Reasonable Accommodation/Modification Request
Authorization for Release of Information

VERIFICATION OF DISABILITY FOR
REASONABLE ACCOMMODATION / MODIFICATION REQUEST

Please print the name of Head of Household: _____

Name of person needing the accommodation: _____

Date of Birth: _____

TO BE COMPLETED BY APPLICANT / TENANT OR HOUSING SPECIALIST:

Description of the proposed reasonable accommodation / reasonable modification.

TO BE COMPLETED BY PHYSICIAN OR OTHER HEALTH CARE PROVIDER:

1. a. In your professional opinion, does the above-named applicant/tenant have a disability (handicap), i.e., a physical or mental impairment which substantially limits one or more major life activities*, or a record of having such an impairment? ☐ Yes / ☐ No

***** *Key terms in the definition of "disability" (handicap) are explained in the attachment.*

b. If "Yes", please provide the initial date of the impairment:_____.

c. If the impairment is expected to last less than a lifetime, please estimate the date that the accommodation(s) or modification(s) will no longer be needed. _____.

2. a. Is there a disability-related need for the above-described proposed reasonable accommodation / reasonable modification based on the applicant's/tenant's physical or mental impairment?

☐ Yes / ☐ No

b. If "Yes", please explain: *(Provide only information that demonstrates a relationship between a disability verified by a "Yes" response to question 1.a., and the proposed reasonable accommodation/modification)* Please **DO NOT DISCLOSE** the specific nature and/or severity of the individual's disability, or provide specific information about his/her diagnosis and treatment.

_____
_____
_____

I certify that the information provided above represents my professional judgment and is true and correct to the best of my knowledge and belief.

_____ _____
Signature of Physician/Health Care Provider Date

Name: _____ Phone: _____

Address: _____

DEFINITIONS

24 C.F.R. § 8.3

Individual with handicaps (disabilities) means any person who 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 does not include an individual who is an alcoholic or drug abuser whose current use of alcohol or drugs prevents the individual from participating in the program or activity in question, or whose participation, by reason of such current alcohol or drug abuse, would constitute a direct threat to property or the safety of others

Physical or mental impairment includes:

(1) Any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: Neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive; digestive; genito-urinary; hemic and lymphatic; skin; and endocrine; or

(2) Any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities. The term physical or mental impairment includes, but is not limited to, such diseases and conditions as orthopedic, visual, speech and hearing impairments, cerebral palsy, autism, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional illness, drug addiction and alcoholism.

NOTE: *Determination of whether a physical or mental impairment substantially limits a major life activity is to be made without regard to the ameliorative effects of mitigating measures (e.g., assess substantial limitation of a major life activity, including the operation of a major bodily function, without considering the benefit of medication, assistive devices, etc., to the individual). In addition, an impairment that is episodic or in remission is a disability if it would substantially limit a major life activity when active.*

Major life activities mean functions such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working.

Has a record of such an impairment means has a history of, or has been misclassified as having, a mental or physical impairment that substantially limits one or more major life activities.

Is regarded as having an impairment means:
(1) Has a physical or mental impairment that does not substantially limit one or more major life activities but that is treated by a recipient as constituting such a limitation;
(2) Has a physical or mental impairment that substantially limits one or more major life activities only as a result of the attitudes of others toward such impairment; or
(3) Has none of the impairments defined in paragraph (a) of this section but is treated by a recipient as having such an impairment.

AUTHORIZATION FOR RELEASE OF INFORMATION

(Please print)

Full Name of Applicant/Tenant: _____

Date of Birth: _____

Local phone: _____ Cell phone: _____

Address: _____

Name of Health Care Provider: _____

Address: _____

Phone: _____

I hereby authorize my Health Care Provider to provide information to the City of Chandler Housing and Redevelopment Division related to my pending request for reasonable accommodation(s) / reasonable modification(s) due to a disability. I further provide my consent to the authorized representatives of the City of Chandler Housing and Redevelopment Division to communicate with my Health Care Provider to obtain clarification, as needed, to determine my eligibility for reasonable accommodation(s)/ reasonable modification(s) due to a disability.

It is my understanding that the information requested by the City of Chandler will be directly related to the following:

- Confirmation that my medical condition is a disability under the Rehabilitation Act, as amended;
- Discussion of why the requested reasonable accommodation/modification is needed;
- Clarification of information previously submitted to the City of Chandler; and/or
- Recommendations regarding alternative accommodations/modifications.

This authorization is valid for twelve months.

_____ _____

Applicant's/Tenant's Signature Date