DISABILITY VERIFICATION

OF NEED FOR REASONABLE ACCOMMODATION OR ACCESSIBLE UNIT FEATURES

To: Date_____

Please provide the name and address of the health care provider or professional in the box above. For example, a health care provider or professional may be a nurse practitioner, nurse, physician's assistant, licensed social worker, physician, psychologist, or case worker who is in a position to know your disability and who can explain how your requested accommodation will address your disability.

RE: _____ _____
Print Applicant/Tenant Name Birth Date

_____ _____
Print Name of Person in household with Disability if Different from Applicant/Tenant Birth Date

Dear Sir/ Madam:

I have asked the Housing Authority of Baltimore City (HABC) to provide a reasonable accommodation to address my disability or the disability of my household member. I have requested the following accommodation:

_____
_____
_____

HABC seeks information to make sure that I have or the household member identified above has a disability and that the reasonable accommodation requested is needed. Below, I am authorizing you to release information that is narrowly tailored to address whether the accommodation I have requested is needed for my disability. I have given HABC permission to use the information you provide for the limited purpose of assessing my reasonable accommodation request. Please complete the attached form, sign your name, and return the form in the self-addressed envelope. Your prompt attention to this matter is requested. If you have any questions, please contact HABC's Housing Operations Office at (410) 396-1941.

AUTHORIZATION TO RELEASE INFORMATION

I, _____(print name), authorize _____to release information verifying my (or my household member's _____) need for accessible housing features and/or accommodations as set forth in my request.

_____ Address: _____
Signature _____

Phone: _____ Date: _____

THIS PAGE TO BE COMPLETED BY HEALTH CARE PROFESSIONAL OR PROVIDER

Name of person requesting reasonable accommodation:_____

1. Does the individual or household member have a disability? ☐ Yes ☐ No

2. If the answer to question 1 is yes, does he/she have a physical disability that results in the need for any accessible housing features or accommodations? ☐ Yes ☐ No

3. If you answered yes to question 1 or 2, is the disability expected to last continuously for at least 12 months or be of indefinite duration? ☐ Yes ☐ No

4. Please indicate below any features or accommodations required by the applicant:

SPECIAL UNIT TYPE NEEDED – CIRCLE ONLY THE ONE TYPE THAT APPLIES; IF NONE APPLIES, PLEASE PROCEED TO THE NEXT SECTION OF THIS FORM:

Yes No Accessible Unit – These units have zero steps, accommodate wheelchairs and other devices and contain the following features:

34" wide doors, for wheelchair or other, passage throughout unit
Accessible kitchen with maneuvering space for a wheelchair
Lowered kitchen sink/counter to 34"– base cabinets removed for wheelchair
Lowered kitchen wall cabinets to 48" height
Accessible bathroom with maneuvering space for a wheelchair
Closets with lowered clothes rods/shelves to 48" height
Lowered electrical wall switches/controls to 48" height

Yes No Unit on One Level

Yes No Unit with Limited Number of Steps (Indicate number of steps ____)

ACCESSIBLE FEATURES NEEDED – CIRCLE ANY THAT APPLY:

Yes No Grab bar(s) in bathtub

Yes No Hand held shower

Yes No Tub seat

Yes No Raised toilet (17" to 19")

Yes No Grab bar(s) at toilet

Yes No Hearing Impaired Features (strobe light smoke alarm and doorbell)

Yes No Vision Impaired Features (Braille stove and thermostat markings)

SPECIAL ACCOMMODATIONS NEEDED – CIRCLE ALL THAT APPLY:

Yes No Live-in aide (explain in detail below)

Yes No Separate bedroom for the person with a disability (explain why below)

Yes No Spare bedroom for medical equipment (describe equipment in detail below)

Yes No Special location within the City (explain in detail below)

Yes No Other features/equipment/needs (explain in detail below)

_____

Signature of Health Care Provider or Professional

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Name of person requesting reasonable accommodation:_____

5.
Please provide further information that would assist us in determining the accessible housing features and/or accommodations in housing required by the individual making the reasonable accommodation request (i.e., features to accommodate devices and equipment used by the applicant, particular needs not addressed by the features listed above, etc.). We do not require details or information about the nature or extent of the disability, rather we need information on how the disability affects the need for the particular accessible feature(s) requested:

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_____

_____
Signature, Health Care provider or professional Date

_____
Print name, title

_____
Name of Organization

_____
Address Phone

_____
City, State, Zip Fax

For Office Use Only: *Data Entry Completed: _____ By: _____*
Date Received: _____

Site Name: _____

Reviewed by: _____
Information Adequate and Complete? If not, please identify what is missing:
_____
_____

Reasonable Accommodation Request Approved by: _____

Accommodation Request Attached?
Notes: