CERTIFICATION OF NEED FOR REASONABLE ACCOMMODATION – THIRD PARY VERIFICATION

This form is preceded by the Request for Reasonable Accommodation release form to be completed by the Applicant, Resident or Participant. All fields must be filled out and the form must be signed and completed in full by an independent person, not by the Applicant, Resident or Participant.

AHA provides reasonable accommodations to our residents with disabilities who have a verifiable need for the reasonable accommodation. A reasonable accommodation is an exception made to the usual rules or policies ***necessary because of a disability*** for the resident to use and enjoy an apartment community. The resident has authorized you to provide the information requested on this form (release form attached).

Name of Resident (print): ______________________________________

Reasonable Accommodation: __________________________

Please complete this form in its entirety.

The Fair Housing Act defines disability as a physical or mental impairment that **substantially** limits one or more major life activities. The disability must be permanent (of continual or long duration) to be protected by the Fair Housing Act. The legal definition of a reasonable accommodation is an exception to the normal rule(s) and/or policy/policies that is necessary for the resident to have an equal opportunity to use and enjoy his/her apartment community.

1. Using the definition above is this resident disabled?

   YES NO I DON'T KNOW

2. If yes, what is the impairment?

   PHYSICAL MENTAL

3. Is the impairment long-term or permanent?

   LONG-TERM PERMANENT

   If not permanent how long will the impairment likely last? _______________
   (Indicate months or years)

Please answer the following questions based on **what limitations** the applicant, resident or participant has when his or her condition (or the family member's condition) is in an active state and what limitations the applicant, resident or participant would have if NO mitigating measures were used. Mitigating measures include things such as medication, medical supplies, equipment, hearing aids, mobility devices, the use of assistive technologies, or auxiliary aids or services, prosthetics and learned behavior or adaptive neurological modifications. Mitigating measures do not include ordinary eye glasses or contact lenses.

With that understanding please answer the following questions:

4.a. Does the impairment substantially limit a major life activity? If yes, what major life activity(ies) is/are affected? (check all that apply below)

YES NO I DON'T KNOW

- Caring for Self
- Interacting with others
- Performing Manual Tasks
- Breathing
- Working
- Walking
- Standing
- Reaching
- Thinking
- Toileting
- Hearing
- Seeing
- Speaking
- Learning
- Sitting
- Lifting
- Sleeping
- Concentrating
- Reproduction
- Other (please describe)

4. b. Does the impairment substantially limit the operation of a major bodily function? (check all that apply below)

YES NO I DON'T KNOW

- Immune
- Normal Cell Growth
- Digestive
- Bowel
- Bladder
- Genitourinary
- Hemic
- Special Senses Organs/Skin
- Lymphatic
- Neurological
- Brain
- Respiratory
- Circulatory
- Endocrine
- Reproductive
- Musculoskeletal
- Cardiovascular
- Other (please describe)

Questions to help determine whether an accommodation is needed:

An applicant, resident or participant (or member of the household) is entitled to an accommodation only when the accommodation is needed because of the disability. Federal regulations stipulate that requests for accommodations will be considered reasonable if they do not create an undue financial and administrative burden for the Housing Authority or result in a fundamental alteration in the nature of the program or services offered. The following questions may help determine whether the requested accommodation is needed because of the disability. (You may use an additional sheet if necessary. You do not have to state the nature and severity of the disability.)

5. What limitation(s) is interfering with the participant's enjoyment of our programs and services?

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6. How does the limitation(s) interfere with his/her ability to have full enjoyment of our programs and services?

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7. Please add the extent to which this limitation interferes with his/her ability to full enjoyment of our programs. (For example if the limitation is walking, you MUST state what is the distance the person can walk. You may give distances and/or how long the person can stand. If the limitation is lifting, please state the maximum pounds the person can lift and the maximum time limits. If the request is for the addition of a live-in aide or caretaker, please provide the particulars of services needed and the length of time (hours or days) that assistance is needed)

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8. Are there any alternate accommodations or modifications that could meet this person's needs in place of what the person is requesting? For example, if there is an alternative way to enable the person to have full enjoyment of the apartment and/or the apartment community, please give details here:

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9. How long have you been treating this person? Please do not include specific details of treatment.

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10. Please state your qualification or professional credentials to make this verification. Please also list your Illinois Medical License Number if you are a physician and/or licensed by the state:

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SPACE INTENTIONALLY LEFT BLANK. PLEASE CONTINUE TO THE FINAL PAGE FOR CERTIFICATION SIGNATURE & DATE

CERTIFICATION:

I understand that I may be contacted by AHA's staff to verify the information I have provided or to provide further information/clarification regarding this request. Furthermore, I understand I may be contacted or otherwise subpoenaed to provide testimony in a court of law, administrative hearing and/or other legal action with respect to the information I have provided herein and/or related to this document.

If not able to provide testimony, you must state the reason: ______________________________

By signing this document, I certify under penalty of perjury that the information and statements I have provided as part of and/or in support of this request for a reasonable accommodation are to the best of my knowledge true and accurate.

______________________________	______________________________
Signature	Date
______________________________	______________________________
Printed Name	Phone:
______________________________	______________________________
Professional Title	Fax