Model Form: Reasonable Accommodation Request Verification

REASONABLE ACCOMMODATION REQUEST VERIFICATION

DATE ____

TO ____
HEALTH CARE PROVIDER'S NAME

____
HEALTH CARE PROVIDER'S ADDRESS

____

FROM ____
COMMUNITY ASSOCIATION NAME

____
COMMUNITY ASSOCIATION ADDRESS

____

RE: **REQUEST FOR ACCOMMODATION**

MEMBER'S NAME____

ADDRESS ____

The member named above has requested that our community association accommodate his/her disability by (state nature of accommodation request): ____

____

Under normal circumstances, our policies would require us to deny the request. However, under federal law, if an individual with disabilities requests a reasonable accommodation to that disability, we must consider the request. To do this, we must verify that the individual qualifies as disabled under federal law and requires the accommodation in order to have an equal opportunity to use and enjoy the his/her home.

We would appreciate your cooperation in answering the questions on this form and returning it to the address listed above. Enclosed is a stamped, self-addressed envelope for this purpose. The member has consented to this release of information, as shown below.

INFORMATION REQUESTED

1. Is member named above disabled as defined below? ☐ Yes ☐ No
2. In your professional opinion, does member named above need the accommodation requested in order to have the same opportunity that a nondisabled individual has to use and enjoy the living quarters? ☐ Yes ☐ No

3. If you answered “Yes” to question number 1, can the member’s condition be otherwise treated to prevent any substantial limits in any of his/her major life activities?

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 an impairment; or is regarded as having such an impairment.

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, Human Immunodeficiency Virus infection, mental retardation, emotional illness, drug addiction, and alcoholism. This definition doesn’t include any individual who is a drug addict and is currently using illegal drugs, or an alcoholic who poses a direct threat to property or safety because of alcohol use.

NAME & TITLE OF PERSON SUPPLYING INFORMATION ____

FIRM/ORGANIZATION ____

Would you be willing to testify in any court action or related proceeding as to member’s need for the requested accommodation? ☐ Yes ☐ No

HEALTH CARE PROVIDER’S SIGNATURE ____

MEDICAL LICENSE # (IF PHYSICIAN) ______________________________ DATE ____________________

RELEASE

TO THE MEMBER:

YOU DO NOT HAVE TO SIGN THIS FORM IF THE NAME OR ADDRESS OF EITHER THE COMMUNITY ASSOCIATION OR THE HEALTH CARE PROVIDER IS LEFT BLANK.

RELEASE: I hereby authorize the release of the requested information. Information obtained under this consent is limited to information that is no older than 12 months. There are circumstances that would require the community association named above to verify information that is up to five years old, which would be authorized by me on a separate consent, attached to a copy of this consent.

SIGNATURE ____ DATE __________________