MEDICAL VERIFICATION

OF NEED FOR REASONABLE ACCOMMODATION OR ACCESSIBLE UNIT FEATURES

To: _____ Date _____

Medical provider's name and address should go in box above

RE: _____ _____
Print Applicant/Tenant Name *Birth Date*

_____ _____
Print Name of Person 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 the household member identified above. 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 will address that disability. Below, I am authorizing you to release information that HABC will use to assess the 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 Choice Voucher Program, at 443-984-2222.

AUTHORIZATION TO RELEASE INFORMATION

I, _____(print name), authorize _____ to release information concerning my (or minor child's _____) needs for accessible housing features and/or accommodations.

_____ Address: _____

Signature

_____

Phone: _____ Date: _____

THIS PAGE TO BE COMPLETED BY MEDICAL 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 Medical Provider:_____

THIS PAGE TO BE COMPLETED BY MEDICAL PROVIDER

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. ***Please specify if the patient needs part-time or 24-hour, 7 days a week care along with the term of the disability. For example, is the disability permanent or temporary?***

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Signature of Medical Provider ***Date***
Must be Signed by Actual Medical Provider

_____
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: