COUNTY OF PRINCE WILLIAM

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OFFICE OF HOUSING AND
COMMUNITY DEVELOPMENT

Billy J. Lake
Director

VERIFICATION OF NEED FOR REASONABLE ACCOMMODATION

Please do not send or attach medical records

Individual Requesting Accommodation _____ DOB_____

Name of PHA Head of Household: _____

Verification must be provided by a professional who is knowledgeable about the individual's situation and competent to render a professional opinion. Such verification may be from a physician, other medical or non-medical service agency professional, or other knowledgeable professional.

Dear Knowledgeable Professional:

Please read this form completely – the information provided here is very important. The individual listed above has identified him or herself as being disabled under the Fair Housing Act and has asked for an accommodation from the Prince William County Office of Housing and Community Development (OHCD) as the Public Housing Agency (PHA) to meet housing-related needs necessary in order to remove, alleviate, or mitigate barriers to their housing or housing programs due to their disability-related limitations.

You have been authorized to release information to us regarding the individual's need for an accommodation. That authorization is attached.

The PHA grants reasonable accommodation requests based in part on verification of need from a qualified professional who has direct experience with an individual's disability, which could include but not be limited to:

- Verification that the person is a qualifying person with disabilities.
- Verification that there is a direct relationship between the nature of the person's disabilities and the accommodation requested.
- Verification that the accommodation is necessary for the person to have equal opportunity to use and enjoy their unit under the housing program, or to equally participate in or access the PHA's programs and services.

Please complete and return this form to PHA. You are welcome to attach additional information or letters (***confidential medical records or any confidential medical information disclosing nature or extent of the disability will not be accepted***), but please note that PHA approval of accommodation requests depends upon verification of the specific standards provided in this form.

If you are not able to verify the information requested in this form, the PHA will notify the family and they may request verification from another professional or licensed practitioner. If you have any questions, or would like further information, please feel free to contact _____ _____, [name and title], at [_____] or [_____].

HOUSING AUTHORITY

VERIFICATION OF NEED FOR ACCOMMODATION

Section I – Verification of Disability

☐ **It is NOT necessary for you to fill out this Section. Please proceed to Section II.**

☐ **Please complete this Section before proceeding to Section II.**

An "individual with a disability" is any person who has a physical, mental or emotional impairment that limits one or more life activities, such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.

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. The definition of an "individual with a disability" does *not* include a person whose current use of alcohol or drugs is the barrier that prevents the person from participating in PHA's housing program and services. (A more detailed definition is provided in the Code of Federal Regulations at 24 CFR 8.3, which PHA staff would be glad to provide to you.)

Does the person named above qualify as an "individual with a disability," according to this definition?

☐ Yes ☐ No ☐ Unable to verify Initials _____

Section II – Verification of Need for Accommodation ***Please do not include medical records***	
I am knowledgeable about this individual's situation.	☐ Yes ☐ No

☐ The household member **needs a live-in aide**. A daily in-home worker, housekeeper, or rotating shifts are not equally effective because: (attach additional paper if needed).

☐ The household member **needs a change in a policy or procedure as a direct result of his/her disability** in order to be afforded an equal housing opportunity. Please explain how the accommodation would alleviate or remove a disability-related limitation. Again, please do not disclose confidential medical information about the nature or extent of the disability. You may use additional paper if needed.

☐ Extra bedroom for medical equipment. Indicate the floor space in square footage of the medical equipment: _____. *All living and sleeping rooms in the current unit are not sufficient to meet the disability-related need because (please indicate):*

☐ **Other.** The household member needs **the following accommodation.** Please explain. Attach additional paper if needed.

CERTIFICATION

Name and address of professional completing this form:_____

_____

Print name:_____

Title:_____License #, if applicable::_____

Address:_____

Telephone:_____ Date:_____

Email:_____ Date:_____

Signature:_____

Please return this form <u>completely</u> filled out as indicated, in sealed envelope, marked <u>CONFIDENTIAL</u> to:

Prince William County Office of Housing and Community Development
Dr. A. J. Ferlazzo Building
15941 Donald Curtis Drive, Suite 112
Woodbridge, VA 22191
ATTN: _____

Or you may fax to _____ or email to _____

Please return by: _____