Medford Housing Authority
121 Riverside Avenue
Medford, MA 02155
781-396-7200

CERTIFICATION OF NEED FOR REASONABLE ACCOMMODATION

THIS FORM MUST BE COMPLETED BY A QUALIFIED MEDICAL, REHABILITATION, OR OTHER NON-MEDICAL SERVICE AGENCY PROFESSIONAL WHOSE FUNCTION IS TO PROVIDE SERVICES TO THE DISABLED AND MAY VERIFY YOUR HOUSEHOLD MEMBER'S NEED FOR A REASONABLE ACCOMMODATION.

(Please be sure to answer all applicable questions on this form.)

Head of Household: _____
Household Member Who Needs an Accommodation: _____
Date of Birth of Member Who Needs an Accommodation: _____
Address: _____
_____
Daytime Phone: (____)_____ Cellular Phone: (_____)_____

The above Household Member is applying for a reasonable accommodation at the Medford Housing Authority ("MHA") and is requesting that you, as his/her provider, fill out the following certification. Enclosed is a copy of the Request for Reasonable Accommodation Form with a signed authorization for release of information.

Please check only those that apply:

In my professional opinion and assessment:

☐ The Household Member has a disability based on one or both of the following legal definitions. Please check each that applies: ☐ He/she has a physical or mental impairment that substantially limits one or more major life activities; or ☐ He/she has a record of having such an impairment.

☐ The Household Member requesting the accommodation(s) does NOT have a disability (proceed to Page 6, sign and return to the address listed on that page.)

How current is your knowledge of the Household member's disability?

☐ I have met with this individual to discuss his/her disability within the last six months. ☐ The last time I met with this individual to discuss his/her disability was over six months ago.

☐ Other (please explain):

_____
_____

Household Member Who Needs Accommodation(s): _____

I. SPECIAL UNIT FEATURES DUE TO DISABILITY

IMPORTANT: Only fill out this section if the disabled Household member needs a unit and/or common area with specific features due to his or her disability. (Otherwise, please proceed to Part II.)

The following information is requested solely for the purposes of identifying the unit (size, type, and design) that most appropriately meets the needs of the disabled Household member. The MHA will make every effort to make the appropriate modifications or identify an appropriate unit based on your professional opinion and assessment. Be advised, certain requested features may inhibit an exact match and/or increase the household's wait for a unit assignment, so please check only those accommodations that are necessary. We will contact the Head of Household when this occurs to offer options and assist in problem-solving alternatives.

Please check all of the following that apply and only those that are necessary: ☐ In my professional opinion and assessment of the disabled Household Member's needs, I certify that:

1. ☐ The disabled Household Member does NOT need a wheelchair-accessible unit but needs a unit or common area with certain physical features. This may include assistive technology. The features required are checked off below with an explanation as to why they are needed given on Page 3.

☐ A maximum # of stairs that may climb to each unit: _____
☐ A maximum distance to walk between the unit and nearest elevator: _____
☐ A minimum floor location: _____
☐ A maximum floor location: _____
☐ A first floor unit or a unit located on an elevator-equipped building is required.
☐ Tub Grab Bars
☐ Toilet Grab Bars
☐ Space for Medical Equipment

Features for the Blind or Hearing Impaired:
☐ Flashing Doorbells
☐ Other. Specify on Page 3.
☐ Single level unit
☐ Handheld Shower
☐ Timers on Stove

Household Member Who Needs Accommodation(s): _____

Continued from Page 2:

2) ☐ The disabled Household Member needs a wheelchair-accessible unit with the following features:

☐ Door Width ›32" if larger: _____ ☐ Roll-Under Stove ☐ Toilet Grab Bars ☐ Shower Seat
☐ Kitchen Turn Radius ›5' ☐ Roll-Under Sink ☐ Handheld Shower ☐ *Side-by-Side Refrigerator ☐Hall Turn Radius ›5' ☐ Tub Grab Bars ☐ *Roll-In Shower
☐ *Wall Oven w/Bread Board

☐ Additional Space for Medical Equipment. Provide details on Page 3. *Note: The number of units with the above features is limited. Be advised that there are a very limited number of units with roll-in showers. Therefore, the wait for these types of units could be lengthy.

3) ☐ The disabled Household member requires a unit in a specific or alternative location due to a disability but does NOT need any physical changes to a unit or common area, and does NOT need a wheelchair-accessible unit. Examples include needing to be in a specific location so as to be close to a specific healthcare facility, or needing to transfer due to a mental disability. Please explain and provide details below.

Please use the space below to explain and provide details as to why the accommodation(s) is necessary as a result of his/her disability in order to enjoy an equal housing opportunity.

a) Describe any other feature, not captured on Page 2, including special housing features, types of physical adaptation, and/or assistive technology (e.g. no carpet in unit and/or common area, etc.) that is necessary due to a disability;

b) Explain in detail why the requested feature(s)/accommodation(s) is necessary due to the disability;

c) Explain for how long the feature(s)/accommodation(s) will be needed; and

d) If the Household Member is a current MHA resident, and a transfer is necessary, explain in detail why. Are there any other alternatives to a transfer that the MHA may provide?

Please be as detailed as possible and print clearly so the MHA may properly review the request. You may continue on Page 5 or attach additional pages or a letter if necessary.

_____
_____
_____
_____
_____
_____

Household Member Who Needs Accommodation(s): _____

Please indicate, if applicable, and if you have such information, where any necessary specialized equipment may be obtained. You may attach additional pages or a letter if necessary.

_____

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_____

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_____

II. CHANGES TO RULES/POLICIES/PROCEDURES DUE TO DISABILITY. IMPORTANT: Only fill out this section if the disabled Household member needs changes to rules, policies or procedures due to his/her disability. Otherwise, please proceed to Part III.

□ The Household Member needs a change in a policy or procedure as a direct result of his/her disability in order to enjoy an equal housing opportunity. Please use the space below to explain what accommodation(s) the disabled Household Member needs, the length for which it will be needed, and why it is required. Use additional paper if needed.

NOTE REGARDING PERSONAL CARE ATTENDANT (PCA): If the disabled Household Member needs a 24-hour OR overnight live-in Personal Care Attendant, please explain in detail:

a) What specific duties the PCA must perform;

b) If your agency will provide the PCA; or

c) If a family member is identified as the PCA, provide the individual's complete name, relationship to disabled Household member, and if that individual is qualified to perform the required duties per your professional opinion and assessment.

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Household member Who Needs Accommodation(s): _____

Additional Writing Space:

Household Member Who Needs Accommodation(s): _____

III. CERTIFICATION

Based on your professional opinion and assessment of needs, please check only one of the following:

☐ I certify that the enclosed request for changes to the unit or common area or to rules, policies and procedures is necessary for the disabled Household member, as a result of his/her disability in order to have an equal housing opportunity, ☐ OR

☐ I cannot certify that the enclosed request is necessary for changes to the unit or common area or to rules, policies and procedures for the disabled Household member, as a result of his/her disability in order to have an equal housing opportunity, ☐ OR

☐ I certify that the identified Household Member is NOT disabled, therefore, does not need a change to the unit or common area or to rules, policies or procedures, as a result of a disability in order to have an equal housing opportunity.

_____

Medical Provider's Signature Date

_____

Name (please print clearly)

_____

Title of medical or rehabilitation professional or expert

_____

Agency or Clinic, if applicable

Complete Address _____

_____

_____

Telephone

Please mail form to: Medford Housing Authority
121 Riverside Avenue
Medford, MA 02155

Hand delivered verifications will not be accepted as a form of official documentation to approve a request for reasonable accommodation.

Patient's Signature: _____

(If patient is a minor, the legal guardian/parent signature is required.)

Print Name: _____ Date: _____