MANCHESTER HOUSING AUTHORITY

24 Bluefield Drive Manchester, CT 06040-4702 860-643-2163 860-643-2999(fax) manchesterha.org

Joseph D'Ascoli Executive Director

CERTIFICATION OF NEED FOR REASONABLE ACCOMMODATION

THIS FORM MUST BE COMPLETED BY A MEDICAL REHABILITATION OR SERVICE AGENCY PROFESSIONAL WHOSE FUNCTION IS TO PROVIDE SERVICES TO THOSE WITH DISABILITIES AND MAY VERIFY YOUR HOUSEHOLD MEMBER'S NEED FOR A REASONABLE ACCOMMODATION.

Any information provided will be evaluated solely for the purpose of making a determination on your Household's request for a reasonable accommodation. Please note that this form was created to assist the Manchester Housing Authority ("MHA") with such evaluations and is not required by disability law. The amount of information you wish to share should be discussed between you and your provider.

Head of Household: _____

Household Member who needs an Accommodation(s): _____

Address: _____

Daytime Phone: ( ) _____ **Cell Phone ( )** _____

The above Household Member is applying for a Reasonable Accommodation and is requesting that you as his/her provider fill out this certification.

Please answer all applicable questions on this form and print clearly. If you need additional writing space, please use page 6 or attach a letter on your official letterhead.

1. In my professional opinion and assessment:

___ **The Household Member <u>has a disability</u> 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.

___ He/she has a record of having such an impairment

___ **The Household Member <u>does not have a disability</u>** based upon the above definition. (Proceed to Part IV, sign and return to the address listed on that page)

2. How current is your knowledge of his/her disability?

___ I have met with this individual to discuss his/her disability within the last six months.

___ I last met this individual to discuss his/her disability over six months ago

___ Other (please explain): _____

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Household Member Who Needs Accommodation(s): _____

Part I. UNIT, COMMON AREA, AND LOCATIONAL FEATURES NEEDED TO DISABILITY

(Only fill out this section if the Household Member needs a unit and/or common area with special features and/or is a current MHA resident who needs a transfer to a unit in a specific location. Otherwise, proceed to Part III)

Please only select features needed due to a disability. The MHA may have a limited number of units with certain combinations of features (leading to a longer wait for a unit assignment) or may not have a unit in its portfolio at all. If the features selected would lead to a long wait or hinder finding a unit with the requested features, the MHA will inform the Head of Household so that further options may be discussed.

In my professional opinion and assessment of the Household member's needs, I certify that:

1. ___ **He/she does need a wheelchair-accessible unit**, due to using a wheelchair/other mobility device, or for another reason (see below for features found only in wheelchair-accessible units).

2. ___ **He/she does not need a wheelchair-accessible unit.**

3. ___ **He/she needs a unit with the below features:**

   ___ A maximum # of stairs that one must climb to reach the unit: _____
   ___ A minimum floor location: _____ ___ A maximum floor location ___ Single level unit
   ___ A Tub grab bars ___ Toilet grab bars ___ Handheld shower ___ *Walk in shower
   ___ Space for medical equipment. (Provide details regarding the equipment and space needed in Part II)

   Features for the blind or those with hearing impairments: ___ Flashing doorbells
   ___ Common area features or other features. (Provide details in Part II)

   (Note: The following features are only found in wheelchair-accessible units)

   ___ Door width >32": _____ ___ Kitchen turn radius >5': _____ ____Hall turn radius >: _____
   ___ Roll-under stove ___ Roll under sink ____ * Roll in shower
   ___ * Side-by side refrigerator

4. ___ **He/she is a current MHA resident and requires a transfer to a specific geographical location due to a disability** (e.g. he/she needs to transfer to be in an area closer to a frequently-visited healthcare facility or because the current area has a detrimental effect on a mental disability) Explain the need for the transfer and where the new unit needs to be in Part II.

Household Member Who Needs Accommodation(s): _____

Part II. DETAILS REGARDING NECESSARY FEATURES

(Only fill out this section if you certified in Part I that the Household Member needs unit, common area, or locational features due to a disability. Otherwise, proceed to Part III.)

1. Please explain in detail why the features found in Part I may be necessary, due to the Household Member's disability, for him/her to enjoy an equal housing opportunity, and for how long the accommodation(s) will be needed. If he/she needs features not found in Part I, such as forms of physical adaptation (e.g.) carpet removal in unit and/or common area, etc.) and/or assistive technology, please describe them below as well.

Household Member Who Needs Accommodation(s): _____

2. If the Household Member is a current MHA resident and you are recommending a transfer to another unit for reasons other than mobility-related needs, please explain:

   a) What conditions in the current unit may be impacting his/her disability:
   b) What activities of the Household Member or others in his/her Household may be impacting his/her disability (e.g. the presence of a smoker or pets for someone with COPD or asthma); and
   c) Whether there are any other alternatives that the MHA may provide, and if not, why.

Have you or a colleague visited his/her current: ___ Yes ____ NO If yes, when was the last visit? _____

Household Member Who Needs Accommodation(s): _____

Part III. CHANGES TO RULES/POLICIES/PROCEDURES DUE TO DISABILITY

(Only fill out this section if the Household Member may need changes to rules, policies or procedures due to his/her disability. Otherwise, proceed to Part IV.)

___ The Household Member **needs a change in policy or procedure due to his/her disability** in order to enjoy an equal housing opportunity.

Please use the space below to explain what accommodation(s) he/she needs, the length for which it will be needed, and why it is needed.

NOTE REGARDING PERSONAL CARE ATTENDANTS (PCAs): If the Household Member needs a **24-hour OR overnight live-in PCA**, please explain:

a) What specific duties the PCA must perform:
b) If the agency will provide the PCA; or
c) If a family member is identified as the PCA, provide the individual's complete name, relationship to the Household Member, and whether that individual is qualified to perform the required duties per your professional opinion and assessment.

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Additional Writing Space:

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Household Member Who Needs Accommodation(s): _____

Part IV. CERTIFICATION

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

___ **I certify** that the accommodation(s) described above may be necessary for the Household Member, as a result of his/her disability, to have an equal housing opportunity.

OR

___ **I cannot certify** that the accommodation(s) described above may be necessary for the Household Member, as a result of his/her disability, to have an equal housing opportunity, **because**:

_____

_____

_____

_____

___ **I certify that the identified** Household Member is **NOT disabled**, and therefore does not need accommodation(s) as a result of a disability in order to have an equal housing opportunity.

_____ _____, 20__

Medical Provider Signature Date

_____ _____

Name of Medical Provider (Please Print Clearly) Title of medical or rehab professional or expert

_____

Agency or Clinic Name

_____

Address

(___)_____ (___) _____

Telephone # Fax #

Please return this form to: **Manchester Housing Authority**
24 Bluefield Drive
Manchester, CT. 06040

Attn: _____

Tel (860) 643-2163 ext. _____ **Fax (860) _____**
(Original documentation needs to be mailed)