CERTIFICATION OF NEED
FOR
REASONABLE ACCOMMODATION or STRUCTURAL MODIFICATION

Dear _____(name of medical professional/independent verifier):

_____(name of Applicant/Resident) has given _____(the landlord/agent) permission to contact you (see attached) to verify that he/she has a disability within the meaning of the definition provided below, and as a direct result of his/her disability, needs a change in a rule, policy, procedure, or service, a physical change in an apartment or other facility or an accessible apartment.

Please do **not** send us medical records or disclose what type of disability he/she has. Please return this form to: _____. Thank you.

Please answer the following questions:

1. **In my opinion, the Applicant or Resident has a disability as defined by one of the categories (a-c) below: [ ] yes [ ] No [ ] No Knowledge**

   (a).Has a physical or mental impairment that substantially limits one or more major life activities;

   (b).Has a record of having such an impairment;

   (c) Is regarded as having such impairment.

NOTE: FOR THE PURPOSE OF THIS FORM, 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, AND DRUG ADDICTION (NOT CURRENT ILLEGAL USE OF A CONTROLLED SUBSTANCE). THE TERM MAJOR LIFE ACTIVITY INCLUDES, BUT IS NOT LIMITED TO WALKING, SEEING, HEARING, SPEAKING, BREATHING, LEARNING, AND WORKING.

1. The applicant/resident has requested the following accommodation and/or physical modification to a unit or other facility. _____.

   (please be specific as to the desired accommodation)

2. **In my opinion the applicant/resident <u>needs</u> the above accommodation/modification as a direct result of his/her disability in order for him/her to apply for and/or reside in a residential housing unit. [ ] Yes [ ] No [ ] No Knowledge**

(there must be a nexus between the disability and the requested accommodation or modification)

Would you be willing to testify in any court action or related proceeding as to the Resident/Applicant's need for the accommodation/modification? [ ] Yes [ ] No

_____

Signature Date

Please have your signature notarized as shown below.

_____

Title of Medical Professional or Other Independent Verifier

_____

Affiliation

_____

Address

_____

Phone

NOTARY PUBLIC

County of _____)
) ss.
State of Colorado)

Subscribed and sworn to before me by _____ this _____ day of _____, 2016.

My commission expires:

(Seal)

_____
Notary Public

PENALTIES FOR MISUSING THIS CONSENT

Title 18, Section 1001 of the U.S. Code states that a person who knowingly and willingly makes false and fraudulent statements to any department of the United States Government, HUD, the PHA, and any owner (or any employee of HUD, the PHA, or the owner) may be subject to penalties for unauthorized disclosures or improper uses of information. CRS § 18-13-107 states that a person who falsely impersonates an individual with a disability, as that term is defined in section 24-34-301(5.6), C.R.S. is guilty of a crime under Colorado law.

Use of the information collected based on this verification form is restricted to the purposes cited above.

The Fair Housing Act prohibits discrimination in housing based on color, race, religion, national origin, sex, family status, or disability.

RESIDENT RELEASE

TO THE RESIDENT:

YOU DO NOT HAVE TO SIGN THIS FORM IF THE NAME OR ADDRESS OF EITHER THE OWNER 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 which would require the owner to verify information that is up to 5 years old, which would be authorized by me on a separate consent attached to a copy of this consent.

SIGNATURE:_____ DATE:_____