

**VERIFICATION OF NEED
FOR REASONABLE ACCOMMODATION/MODIFICATION**

TO BE COMPLETED BY THE INDIVIDUAL REQUESTING THE REASONABLE ACCOMODATION

Requestor's Name: _____ **Phone:** _____

Address: _____ **DOB:** _____ **AMP#** _____

I have applied for a Reasonable Accommodation request and request that you fill out the following verification for the following requested program change or accommodation:

Signed: _____ **Date:** _____

TO BE COMPLETED BY QUALIFIED THIRD PARTY PROFESSIONAL

1. In my opinion as a qualified third party professional, the requestor has a disability as defined below:

- A. A physical or mental impairment that substantially limits one or more major life activities.
- B. A record of having such an impairment; and
- C. Being regarded as having such an impairment.

Yes No

2. In my opinion, the requestor's **disability requires** that **the stated accommodation** is necessary in order for the tenant to have the same access or benefit from the program that a non-disabled person would have.

Yes No

Please describe any additional modification or accommodation that you believe is necessary **without** providing the medical details or diagnosis:

I **do not believe** requestor needs a change to the policies and procedures as a result of his/her disability to have an equal housing opportunity.

I **cannot verify** that the enclosed request is necessary for the above named person, as a result of his/her disability to have equal housing opportunity.

Signature

Date

Title of Qualified Third Party Professional Verifier

Address

Phone