



# PROVIDENCE HOUSING AUTHORITY

100 BROAD STREET  
PROVIDENCE, RI 02903-4129  
Tel. (401) 751-6400  
Fax (401) 351-1191

## VERIFICATION OF NEED FOR REASONABLE ACCOMMODATION PUBLIC HOUSING PROGRAM

***Please do not send or attach medical records***

Individual Requesting Accommodation \_\_\_\_\_

Name of PHA Head of Household: \_\_\_\_\_

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 Providence Housing Authority (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 Providence Housing Authority grants reasonable accommodation requests based, if necessary, on verification of need from a professional who is knowledgeable about the individual's situation and competent to render an opinion. Such verification may be from a physician, other medical or non-medical service agency professional, or other knowledgeable professional. Verification could include but not be limited to:

- Verification that the person is a qualifying person with disabilities.
- Verification that there is a direct relationship ("nexus") 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 participate in or access the PHA's programs and services.

Please complete and return this form to the PHA. ***Confidential medical records will not be accepted.***

If you are not able to verify the information requested in this form, the Providence Housing Authority 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 the PHA's Associate Director of Property Management, Jacqueline Martinez, at 401-709-1303.

**Please return form to: PHA Property Management Office.**

## 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 Requested Accommodation

***Please do not include medical records***

I am knowledgeable about this individual’s situation.

Yes     No

**In my professional assessment of the disabled individual’s needs, I certify that:**

- The disabled individual **requires a live-in aide**. A daily in-home worker or rotating shifts are not adequate to provide an opportunity equal to that afforded others.
- The disabled individual requires an extra bedroom for medical equipment (note: if necessary, a PHA inspector may view the equipment to confirm that all sleeping and living spaces are not adequate as an accommodation)
- The disabled individual **requires 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 what change in policy or procedure is being requested.

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**Please return form to: PHA Property Management Office.**

## CERTIFICATION

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

- I certify** that the enclosed request for an accommodation is necessary for the disabled household member, as a result of their disability-related limitations, in order to have an equal housing opportunity.

**OR**

- I cannot certify** that the enclosed request is necessary for the disabled household member, as a result of their disability-related limitations, in order to have an equal housing opportunity.

**Please certify below:**

- This certification is true and accurate to the best of my professional judgment.

\_\_\_\_\_  
Professional's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name (Please print clearly)

\_\_\_\_\_  
Title of professional

\_\_\_\_\_  
Agency or Clinic, if applicable

\_\_\_\_\_  
Complete Address

(\_\_\_\_) \_\_\_\_\_  
Phone

(\_\_\_\_) \_\_\_\_\_  
Fax

\_\_\_\_\_  
Email

**Please return form to: PHA Property Management Office.**