CHELMSFORD HOUSING AUTHORITY
10 Wilson St Chelmsford Ma 01824
(978)-256-7425

CERTIFICATION OF NEED FOR REASONABLE ACCOMMODATION

THIS FORM MUST BE COMPLETED BY A QUALIFIED MEDICAL, REHABILITATION, OR OTHER 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 Chelmsford Housing Authority ("CHA") 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 box of 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 last page to certify, 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):

_____

_____

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I. SPECIAL UNIT FEATURES DUE TO DISABILITY

IMPORTANT: Only fill out this section if the disabled Household member needs a unit and/or certain unit size 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 that most appropriately meets the needs of the disabled Household member. The CHA will make every effort to identify the unit size 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:

☐ Additional Space/Bedroom for Medical Equipment.

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

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

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

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II. . CHANGES TO POLICIES/PROCEDURES DUE TO DISABILITY.

IMPORTANT: Only fill out this section if the disabled Household member needs changes to 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.

Additional Information to consider:

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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 size, 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 request is necessary for changes to the unit size, 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 size, policies or procedures, as a result of a disability in order to have an equal housing opportunity.

☐ I certify that the identified Household Member is disabled, and this accommodation would be helpful but is not necessary as a result of his/her 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 send form to: Chelmsford Housing Authority
Attn. Kelly Santos- Director of Leased Housing
10 Wilson Street
Chelmsford, MA 01824