CERTIFICATION OF NEED FOR REASONABLE ACCOMMODATION AND THIRD PARTY VERIFICATION

This form is preceded by the Request for Reasonable Accommodation to be completed by the Applicant, Resident or Participant. All fields must be filled out, and the form must be signed and completed in full by an independent person, not by the Applicant, Resident, or Participant.

Date: _____

Name of party requesting the Reasonable Accommodation _____

Client Number (if known) _____

Address_____

City_____ State_____ Zip: _____

Please return to the ADA/Section 504 Coordinator, Housing Authority of Cook County, 175 W. Jackson Blvd., Suite 350, Chicago, IL 60604. Telephone: (312) 542-4683 TTY: (312) 341-1450 Fax: (312) 692-0115

Important: This form is to be completed by a doctor who is familiar with the person's disability and need for the requested accommodation. This section may <u>not</u> be completed by the Applicant, Resident, or Participant.

We are not inquiring as to diagnosis, treatment, or the extent and severity of the disability.

Explanation: The Housing Authority of Cook County **(**HACC) is required by law to provide reasonable accommodations to disabled applicants, residents, and participants in its programs when the accommodations will facilitate their ability to function and provide equal opportunity to use and enjoy our housing programs. Applicable federal and state law defines "disability" with respect to the individual as (1) a physical or mental impairment which substantially limits one or more of such person's major life activities; (2) a record of having such an impairment; but such terms do not include current illegal drug use or addiction to a controlled substance, or an alcoholic who poses a direct threat to property or safety because of alcohol use. The following questions may help determine whether the applicant, resident or participant (or a member of the household) has a disability:

1. I have knowledge that _____
(Name of Applicant/Resident/Participant or Household Member)

2. **Has a physical or mental impairment** ☐ Yes ☐ No

If yes, what is the impairment? ☐ Physical ☐ Mental

3. Is the impairment long-term or permanent? ☐ Long-Term ☐ Permanent

If not permanent, how long will the impairment likely last? _____ (Indicate months or years)

4. Please answer the following questions based on **<u>what limitations</u>** the applicant, resident or participant has when his or her condition (or the family member's condition) is in an active state and what limitations the applicant, resident or participant would have if NO mitigating measures were used. Mitigating measures include things such as medication, medical supplies, equipment, haring aids, mobility devices, the use of assistive technology, reasonable accommodations, or auxiliary aids or services, prosthetics and learned behavioral or adaptive neurological modifications. Mitigating measures do not include ordinary eyeglasses or contact lenses.

5. Does the impairment substantially limit a major life activity? ☐ Yes ☐ No
If yes, what major life activity (ies) is/are affected?

☐ Caring for Self	☐ Walking	☐ Hearing	☐ Lifting	☐ Other:
☐ Interacting with others	☐ Standing	☐ Seeing	☐ Sleeping	(describe)
☐ Performing Manual Tasks	☐ Reaching	☐ Speaking	☐ Concentrating	
☐ Breathing	☐ Thinking	☐ Learning	☐ Reproduction	
☐ Working	☐ Toileting	☐ Sitting		

6. Does the impairment substantially limit the operation of a major bodily function? ☐ Yes ☐ No
If yes, what major bodily function(s) is/are affected?

Note: Does not need to significantly or severely restrict to meet this standard.

☐ Immune	☐ Hemic	☐ Circulatory	☐ Other: (describe)
☐ Normal Cell Growth	☐ Special Sense Organs /Skin	☐ Endocrine	
☐ Digestive	☐ Lymphatic	☐ Reproductive	
☐ Bowel	☐ Neurological	☐ Musculoskeletal	
☐ Bladder	☐ Brain	☐ Special Sense	
☐ Genitourinary	☐ Respiratory	☐ Cardiovascular	

Questions to help determine whether an accommodation is needed:

An applicant, resident or participant (or member of the household) is entitled to an accommodation only when the accommodation is needed because of the disability. Federal regulations stipulate that requests for accommodations will be considered reasonable if they do not create an undue financial and administrative burden for the Housing Authority, or result in a fundamental alteration in the nature of the program or services offered. The following questions may help determine whether the requested accommodation is needed because of the disability.
***(You may use additional sheet, if necessary. You do not have to state the nature and severity of the disability*).**

7. What limitation(s) is interfering with the participant's enjoyment of our programs and services?

_____

_____

8. How does the limitation(s) interfere with his/her ability to have full enjoyment of our programs and services?

_____

_____

Housing Authority of Cook County
175 W. Jackson Blvd., Suite 350 ● Chicago, IL 60604 ● (312) 663-5447

9. Please add the extent to which this limitation interferes with his/her ability to full enjoyment of our programs? (For example if the limitation is walking, YOU MUST state what is the distance the applicant, resident or participant (or household member) can walk. You may give distances and/or how long the applicant, resident or participant can stand. If the limitation is lifting, please state the maximum pounds the applicant, resident or participant can lift and the maximum time limits. If the request is for the addition of a live-in aide or caretaker, please provide the particulars of services needed and the length of time (hours or days) that assistance is needed.)

_____

_____

10. Are there any other alternate accommodations or modifications that could meet the applicant's, resident's, participant's or household member's needs in place of what the applicant, resident, participant or household member has requested. For example, if there is an alternative way to enable the applicant, resident, participant or household member to have full enjoyment of the apartment and/or the apartment community, please give details here:

_____

_____

11. How long have you been treating the household member? Please do **not** include specific details of treatment).

_____

12. Please state your qualifications or professional credentials to make this verification, please also list your Illinois Medical License Number if you are a physician or licensed by the state:

_____

CERTIFICATION:

I understand that I may be contacted by HACC's staff to verify the information I have provided or to provide further information/clarification regarding this request. Furthermore, I understand that I may be contacted or otherwise subpoenaed to provide testimony in a court of law, administrative hearing and/or other legal action with respect to the information I have provided herein or related to this document.

If not able to provide testimony, you must state the reason: _____

By signing this document, I certify under penalty of perjury that the information and statements I have provided as part of and/or in support of this request for a reasonable accommodation are to the best of my knowledge true and accurate.

_____ _____

Signature Date

_____ _____

Printed Name Phone:

_____ _____

Professional Title Fax: