Certification of Need for Reasonable Accommodation and Third-Party Verification – Multifamily

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 not be completed by the Applicant, Resident, or Participant**.

Date:		**Client Number:**
Name of party requesting the Reasonable Accommodation:		**Telephone Number:**
Address:		
City:	**State:**	**ZIP Code:**

Please return to:

Housing Authority of Cook County
ATTN: 504 Coordinator
10 South La Salle Street, Suite 2200 Chicago, Illinois 60603.
Email: 504@thehacc.org

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. Name of Applicant/Resident/Participant: _____
2. In my professional opinion and assessment: _____

□ **The Individual requesting the accommodation(s) 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 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.**

3. **Please check only one of the following:**

□I certify that the Request for Reasonable Accommodation is necessary for the Applicant/Resident/Participant to have an equal housing opportunity as result of his/her disability.

□I do not certify/believe that the Request for Reasonable Accommodation is necessary for the Applicant/Resident/Participant to have an equal housing opportunity as result of his/her disability.

4. Please describe the relationship between the reasonable accommodation and the disability:

_____

_____

5. Please describe the participant's limitation. For example, if the limitation is:

- Unable to care for oneself, live-in aide or caretaker needed: please provide the particulars of services needed and the length of time (hours or days) that assistance is needed.
- Walking: please state what is the distance the applicant, resident or participant can walk. You may give distances and/or how long the applicant, resident or participant can stand.
- Lifting: please state the maximum pounds the applicant, resident or participant can lift and the maximum time limits.

_____

_____

6. 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?

_____

_____

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

_____

8. 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:**
Print Name:	**Telephone Number:**
Professional Title:	**Fax Number:**