



**BOSTON HOUSING AUTHORITY**

Occupancy Department  
52 Chauncy Street, 3<sup>rd</sup> Floor  
Boston, Massachusetts 02111-2375

617-988-4200  
TDD 1-800-545-1833 Ext. 420  
www.BostonHousing.org

**CERTIFICATE OF INVOLUNTARY DISPLACEMENT BY  
INACCESSIBILITY OF THE DWELLING UNIT**

This form is available in an alternative format upon request.

**DEFINITION:**

A member of the Household has a mobility or other impairment that makes the person unable to use a critical element of the current apartment or development AND the owner is not legally obligated, under laws pertaining to Reasonable Accommodation, to make changes to the apartment or dwelling unit that would make these critical elements accessible to the Household Member with the disability.

**DOCUMENTATION REQUIRED:**

**Failure to provide ALL required documentation will result in denial of priority request.**

- ◆ Submission of a fully completed "Certificate of Involuntary Displacement by Inaccessibility of the Dwelling Unit"; **or**
- ◆ The name of the household member who is unable to use the critical element; **and**
- ◆ A written statement from a Qualified Healthcare Provider verifying that the household member has a Disability (but not necessarily the nature of the Disability) and identifying the critical element of the dwelling which is not accessible and the reasons why it is not accessible; **and**
- ◆ A statement from the landlord or official of a government or other agency providing service to such Disabled Persons explaining the reason(s) that the landlord is not required to make changes which would render the dwelling accessible to the individual as a reasonable accommodation.

**TO BE COMPLETED BY THE APPLICANT:**

I, \_\_\_\_\_, (SS#: - \_\_\_\_\_ - \_\_\_\_\_), authorize the release of the above information to the Boston Housing Authority. I also hereby certify that I have not secured standard, permanent replacement housing to resolve the housing need which I have claimed as a priority status applicant for public housing. I agree that if my circumstances should change at any time, I will immediately notify the BHA's Occupancy Department ***in writing*** (electronic/fax messages are not acceptable).

I understand that any falsification, misrepresentation or concealment of information will be considered grounds for denying admission to BHA housing for a period of three (3) years.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name (Please Print): \_\_\_\_\_

**Please identify the critical element(s) of the dwelling unit which you or a household member are unable to use because of mobility or other impairment:** \_\_\_\_\_

**Please identify the name of the household member affected:** \_\_\_\_\_

**BOTH SECTIONS A AND B OF THIS FORM MUST BE COMPLETED FOR THIS PRIORITY. IT IS SUGGESTED THAT SECTION A BE COMPLETED FIRST TO AVOID THE DISCLOSURE OF CONFIDENTIAL MEDICAL INFORMATION TO YOUR LANDLORD. SECTION B IS ON THE REVERSE SIDE.**

**SECTION A: THIS SECTION SHOULD BE COMPLETED BY THE CURRENT LANDLORD OR PROPERTY MANAGER.**

1. Is the above applicant or identified household member a tenant of record?

Yes  Move-in Date \_\_\_\_\_ No

2. Do any barriers exist which affect the individual's ability to use critical elements of the dwelling unit because of his or her impairment?

Yes  No  If Yes, please identify and describe the barrier(s) below:

\_\_\_\_\_  
\_\_\_\_\_

3. Please check below which type of housing best describes the property in which the applicant or household member resides.

- Publicly-assisted housing (subsidized)
- Non-publicly assisted housing
- Multiple dwelling housing consisting of 10 or more units.
- Contiguously located housing consisting of 10 or more units.
- A building with three or more housing units.  
Enter date of construction or original occupancy of building \_\_\_\_\_
- Other

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Title: \_\_\_\_\_  
Owner/Manager/Agency Name

Address: \_\_\_\_\_

Daytime Phone: (\_\_\_\_\_) \_\_\_\_\_

**SECTION B: THIS SECTION SHOULD BE COMPLETED BY A QUALIFIED HEALTHCARE PROVIDER WHO PROVIDES CARE TO THE INDIVIDUAL CLAIMING A PRIORITY NEED.**

1. Please indicate the name of the individual to whom the following information pertains (PLEASE PRINT CLEARLY): \_\_\_\_\_

2. Does this individual have any limitation(s), mobility or other impairment(s) which affect his/her ability to use critical elements of the current dwelling unit? Yes  No

If yes, please describe the limitation(s) or impairment(s). \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

3. Based on information provided in Section A (see reverse), is the individual unable to use critical elements of the dwelling unit because of the limitation(s), mobility or other impairment(s) described above?  
Yes  No

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Title: \_\_\_\_\_

Agency Name: \_\_\_\_\_  
(If applicable)

Address: \_\_\_\_\_

Daytime Phone: (\_\_\_\_\_) \_\_\_\_\_



This is an important notice. Please have it translated.  
 Este é um aviso importante. Queira mandá-lo traduzir.  
 Este es un aviso importante. Sirvase mandarlo traducir.  
**ĐÂY LÀ MỘT BẢN THÔNG CÁO QUAN TRỌNG**  
**XIN VUI LÒNG CHO DỊCH LẠI THÔNG CÁO ẤY**  
 Ceci est important. Veuillez faire traduire.  
**本通知很重要。請將之譯成中文。**  
**នេះគឺជាជំនាញសំខាន់ណាស់ សូមមេត្តាបកប្រែជូនផង**

