



Boston Housing Authority
 _____ Dpt.
 52 Chauncy Street
 Boston, Massachusetts 02111-02375

Phone: 617-988-_____
 TDD 1-800-545-1833 Ext. 420
 www.bostonhousing.org

CERTIFICATION OF NEED FOR REASONABLE ACCOMMODATION

THIS FORM MUST BE COMPLETED BY A QUALIFIED MEDICAL, REHABILITATION OR OTHER NON-MEDICAL SERVICE AGENCY PROFESSIONAL WHOSE FUNCTION IS TO PROVIDE SERVICES TO THE DISABLED AND MAY VERIFY THE NEED.

(Please be sure to answer all applicable questions on this form.)

Head of Household: _____ **Client #:** _____

Household Member Who Needs Accommodation: _____

Address: _____ **Unit#** _____

Daytime Phone (_____) _____ Cellular Phone (_____) _____

The above household member is applying for a reasonable accommodation at the Boston Housing Authority (BHA) 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 his/her signature for release of information.

1. Please indicate how current your knowledge is regarding this individual:

Within the last six months _____ Over the last six months _____

Other (please explain) _____

Please check only those that apply:

2. In my opinion, the Applicant/Resident has a disability as defined below:

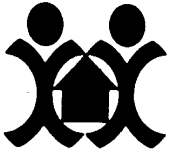
YES (please continue)

NO (proceed to page 4, sign and return to the address listed on that page.)

A) _____ A physical or mental impairment that substantially limits one or more major life activities.

B) _____ A record of having such an impairment.

C) _____ Is regarded as having such an impairment.



Boston Housing Authority

_____ Dpt.
52 Chauncy Street
Boston, Massachusetts 02111-02375

Phone: 617-988-_____

TDD 1-800-545-1833 Ext. 420
www.bostonhousing.org

NOTE: The following information is requested solely for the purposes of identifying the apartment of the most appropriate size, type and design for the applicant/resident and will not be used for any other purpose. The BHA will make every effort to make the appropriate modifications or identify an appropriate apartment based on your professional opinion outlined herein. If a transfer to another unit is the only solution, an apartment will be assigned to the applicant/resident when s/he is reached on the waiting list and when such a unit that matches his/her characteristics becomes available. **Certain requested features may inhibit an exact match and/or increase the applicant/resident's time on the waiting list, so please check only those accommodations that are necessary.** We will contact applicants/residents when this occurs to offer options and assist in problem-solving alternatives.

3. In my opinion, the Applicant's/Resident's disability **does not require** a wheelchair accessible unit but **does require other physical modifications to the apartment or common area, including assistive technology** in order for the Applicant/Resident to have equal opportunity to live successfully in BHA housing.

YES (Please describe all the special features this applicant/resident needs and indicate or check off all that apply below).

Maximum # of stairs may climb to unit: _____ **Maximum steps may walk to elevator:** _____

Maximum floor location: _____ **First Floor or Elevator:** _____

NO (please continue)

Please describe any other special housing features, types of physical adaptation and/or assistive technology (i.e. flashing doorbell, flashing timer on stove, no carpet in unit, no carpet in common area, no more than 3 consecutive stairs, etc.) that are **necessary** as a result of his/her disability in order for him/her to enjoy an equal housing opportunity, please **print clearly** and explain why the accommodation(s) is/are required:

Also, please indicate, if applicable and if you have such information, where any specialized equipment may be obtained:



Boston Housing Authority
 _____ Dpt.
 52 Chauncy Street
 Boston, Massachusetts 02111-02375

Phone: 617-988-_____
 TDD 1-800-545-1833 Ext. 420
 www.bostonhousing.org

4. In my opinion, the Applicant/Resident's disability **does require** that a **wheelchair accessible** apartment be made available to the household:

YES Please describe all the **necessary** requirements this applicant/resident needs and **check below only** those that apply :

Door Width>32": _____ Kitchen Turn>5': _____ Hall Radius>5': _____

Roll-Under Stove: _____ *Roll-Under Sink: _____ Tub Grab Bars: _____

Toilet Grab Bars: _____ Handheld Shower: _____ *Roll-In Shower: _____

*Side-by-Side Refrigerator: _____

Note: * The number of units with these features is limited, therefore the wait will be long.

NO (please continue)

In addition, the following features, not captured above or on the previous page, are **necessary** for the Applicant's/Resident's wheelchair accessible unit. If additional unit space is required explain in detail why and provide the equipment and/or room measurements:

5. In my opinion, the Applicant/Resident **does not need any physical changes or modifications to an apartment**, but an accommodation in rules or a change in a policy or procedure **is necessary** as a direct result of his/her disability in order to enjoy an equal housing opportunity.

YES Please describe (i.e. needs to be in a specific location and why; near a specific healthcare facility; or needs a **24 hour or overnight live-in personal care attendant** to provide what specific duties. If your agency will provide the personal care attendant, or if a family member is identified, is that individual qualified per your professional opinion? Provide complete name of the identified personal care attendant): _____

NO (please continue)



Boston Housing Authority

_____ Dpt.
52 Chauncy Street
Boston, Massachusetts 02111-02375

Phone: 617-988-_____

TDD 1-800-545-1833 Ext. 420
www.bostonhousing.org

(Please be sure to answer all applicable questions on this form.)

6. Based on your professional opinion, you: (Please check only one of the following)

[] **Certify** that the enclosed request for changes to the apartment or common area or to rules, policies and procedures is necessary for the Applicant/Resident, as a result of his/her disability in order to have an equal housing opportunity.

OR

[] **Cannot certify** that the enclosed request is necessary for changes to the apartment or common area or to rules, policies and procedures for Applicant/Resident, as a result of his/her disability in order to have equal housing opportunity.

OR

[] **Do not believe** the Applicant/Resident needs a change to the apartment or common area or to rules, policies or procedures, as a result of his/her disability in order to have an equal housing opportunity.

Signature

Date

Name (Please print clearly)

Title of medical or rehabilitation professional or expert

Agency or Clinic, if applicable

Complete Address

(_____) _____
Phone

(_____) _____
Fax

Please return form to:

Boston Housing Authority

Attn: _____

Address: _____

Boston, MA _____

Telephone: (617)988-_____

Fax: (617)988-_____ ***(Original must be mailed)***