



Boston Housing Authority
 Occupancy Department.
 52 Chauncy Street, 3rd Floor
 Boston, Massachusetts, 02111-02375

Phone: 617-988-3400
 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 YOUR HOUSEHOLD MEMBER'S NEED FOR A REASONABLE ACCOMMODATION.

NOTE: IF THE NECESSARY ACCOMMODATION IS ASTHMA-RELATED, PLEASE ALSO COMPLETE THE ASTHMA QUESTIONNAIRE FORM.

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

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

Household Member Who Needs an Accommodation(s): _____

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 a signed authorization for release of information.

Please check only those that apply:

1. 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.

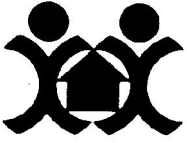
The Household Member requesting the accommodation(s) does NOT have a disability (proceed to Page 6, sign and return to the address listed on that page.)

2. 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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Household Member Who Needs Accommodation(s): _____ Client #: _____

I. SPECIAL UNIT FEATURES DUE TO DISABILITY

IMPORTANT: Only fill out this section if the disabled Household Member needs a unit and/or common area with specific features 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, type, and design) that most appropriately meets the needs of the disabled Household Member. The BHA will make every effort to make the appropriate modifications or identify an appropriate unit 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:

- 1) The disabled Household Member **does NOT** need a wheelchair-accessible unit but needs **a unit or common area with certain physical features**. This may include assistive technology. The features required are checked off below with an explanation as to why they are needed given on **Page 3**.

A maximum # of stairs that may climb to reach the unit: _____

A maximum distance to walk between the unit and nearest elevator: _____

A minimum floor location: _____ A maximum floor location: _____ Single level unit

A first floor unit or a unit located on an elevator-equipped building is required.

Tub Grab Bars Toilet Grab Bars Handheld Shower

Shower Seat Space for Medical Equipment.

Features for the Blind or Hearing Impaired: Flashing Doorbells Timers on Stove

Other. **Specify on Page 3.**

- 2) The disabled Household Member needs **a wheelchair-accessible unit with the following features:**

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

Roll-Under Stove Roll-Under Sink Tub Grab Bars

Toilet Grab Bars Handheld Shower *Roll-In Shower

Shower Seat *Side-by-Side Refrigerator *Wall Oven w/ Bread Board

Additional Space for Medical Equipment. **Provide details on Page 3.**

***Note:** The number of units with the above features is limited. Be advised that there are a very limited number of units with roll-in showers. Therefore, the wait for these types of units could be lengthy.



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Please indicate, if applicable, and if you have such information, where any necessary specialized equipment may be obtained. You may attach additional pages or a letter if necessary.

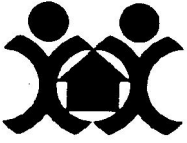
II. CHANGES TO RULES/POLICIES/PROCEDURES DUE TO DISABILITY

IMPORTANT: Only fill out this section if the disabled Household Member needs changes to rules, 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.



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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 or common area or to rules, 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 enclosed request is necessary for changes to the unit or common area or to rules, policies and procedures for the disabled Household Member, as a result of his/her disability in order to have equal housing opportunity.

OR

I do not believe the disabled Household Member needs a change to the unit or common area or to rules, policies or procedures, 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 or common area or to rules, policies or procedures, as a result of a 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

(_____) _____
 Phone

(_____) _____
 Fax

Please return form to: **Boston Housing Authority**
Attn: _____
Address: _____
Boston, MA _____
Telephone: (617)988-_____
Fax: (617)988-_____ **(Original must be mailed)**