FARGO HOUSING & REDEVELOPMENT AUTHORITY

325 N Broadway ● Fargo, ND 58102 ● www.fargohousing.org
Main (701) 293-6262 ● TTY (800) 627-3529 ● Fax (701) 293-6269

EQUAL HOUSING OPPORTUNITY

REQUEST FOR REASONABLE ACCOMMODATION

Date of Request: _____ **Head Of Household:**_____ **Phone:**_____

Address:_____

1. The following member of my household has a disability as defined below:
   (A physical or mental impairment that substantially limits one or more major life activities; a record of having such an impairment; or being regarded as having such an impairment.)

   Name:_____ Social Security No._____

2. As a result of his/her disability the following change or changes are requested so that (the person listed) can live here as easily or successfully as the other residents. **Check the kind of change(s) you need.**
   [ ] Companion Animal
   [ ] Exception Payment Standard
   [ ] A change in my unit or other part of the housing complex. Please describe request:

   _____

   _____

   [ ] A change in rule, policy or procedure. Everyone must continue to meet the terms of the lease. Please describe request: _____

   _____

3. My reason(s) for requesting this reasonable accommodation:_____

   _____

   _____

4. Please give the name and address of the physician, licensed health care professional, professional representing a social service agency, disability agency or clinic who may provide verification of your disability and the need of this reasonable accommodation:

   Name:_____ Telephone:_____

   Title:_____ Address:_____

I give you permission to contact the above individual for purposes of verifying that I or a family member have/has a disability and need(s) the reasonable accommodation requested above. I understand that the information will be kept confidential and used to determine if a reasonable accommodation will be approved.

_____ _____
Head of Household Date

_____ _____
Fargo Housing Manager Date

{ } Coordinator Approved

DISABILITY VERIFICATION FORM FOR FHRA

Name of Medical Professional: _____
Address: _____

PLEASE RETURN FORM TO:

Fargo Housing & Redevelopment Authority
PO Box 430
Fargo, ND 58107-0430
Phone#: 701-293-6262
Fax#: 701-293-6269

SUBJECT: Verification of Information Supplied by an Applicant/Tenant for Housing Assistance

NAME: _____
ADDRESS: _____

This person has applied for housing assistance under a program of the U.S. Department of Housing and Urban Development (HUD). HUD requires the housing owner to verify all information that is used in determining this person's eligibility or level of benefits.

We ask for your cooperation in providing the following information and returning it to the person listed at the top of this page. Your prompt return of this information will help to ensure timely processing of the application for assistance. The applicant/tenant has consented to this release of information as shown below.

Area to be completed by a Medical Professional

For each numbered item below, mark an "X" in the applicable box that accurately describes the person listed above.

1. _____Yes_____No Has a disability, as defined in 42 U.S.C. 423, which means:
   a. Inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months; or
   b. In the case of an individual who has attained the age of 55 and is blind, inability by reason of such blindness to engage in substantial gainful activity requiring skills or abilities comparable to those of any gainful activity in which he/she has previously engaged with some regularity and over a substantial period of time.
2. _____Yes_____No Has a physical, mental, or emotional impairment that:
   a. Is expected to be of long-continued and indefinite duration;
   b. Substantially impedes his or her ability to live independently; and
   c. Is of such a nature that the ability to live independently could be improved by more suitable housing conditions.
3. _____Yes_____No Has a developmental disability as defined in Section 102(7) of the Developmental Disabilities Assistance and Bill of Rights Act 42 U.S.C. 6001(8), i.e., a person with a severe chronic disability that:
   a. Is attributable to a mental, or physical impairment or combination of mental and physical impairments;
   b. Is manifested before the person attains age 22;
   c. Is likely to continue indefinitely;
   d. Results in substantial functional limitation in three or more of the following areas of major life activity: (1) Self-care, (2) Receptive and expressive language (3) Learning (4) Mobility, (5) Self-direction, (6) Capacity of independent living, and (7) Economic self-sufficiency; and
   e. Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are of lifelong or extended duration and are individually planned and coordinated.
4. _____Yes_____No Is the above a person who's disability is based solely on any drug or alcohol dependence.

As a qualified professional, I certify that the following accommodation is consistent with the needs associated with the client's disability, and that there is a nexus between the disability and the requested accommodation. Please describe the accommodation needed to provide the individual with an equal opportunity to use or enjoy a dwelling unit, and/or participate in or have access to programs and activities sponsored by the Housing Authority.

_____

_____

Name and Title of Person Supplying the Information | Firm/Organization Name | Signature | Email of the provider

RELEASE: I hereby authorize the release of the requested information. Information obtained under this consent is limited to information that is no older than 12 months. There are circumstances that would require the owner to verify information that is up to 5 years old, which would be authorized by me on a separate consent attached to a copy of this consent.

_____
Signature Date

NOTE TO APPLICANT/TENANT: You do not have to sign this form if either the requesting organization or the organization supplying the information is left blank.
PENALITIES FOR MISUSING THIS CONSENT: Title 18, Section 1001 of the U.S. Code states that a person is guilty of a felony for knowingly and willingly making false or fraudulent statements to any department of the United States Government. HUD and any owner (or any employee of HUD or the owner) may be subject to penalties for unauthorized disclosure or improper uses of information collected based on the consent form. Use of the information collected based on this verification form is restricted to the purposes cited above. Any person who knowingly or willingly requests, obtains, or discloses any information under false pretenses concerning an applicant or participant may be subject to a misdemeanor and fined not more than $5,000. Any applicant or participant affected by negligent, disclosure of information may bring civil action for damages and seek other relief, as may be appropriate, against the officer or employee of HUD or the owner responsible for the unauthorized disclosure or improper use. Penalty provisions for misusing the social security number are contained in the Social Security Act at 208(a) (6), (7) and (8). Violations of these provisions are cited as violations of 42 U.S.C. 408 (a) (6), (7) and (8).

Please return the form to the address listed above. Thank you.

EXPLANATION TO THE APPLICANT

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MEDICAL PROFESSIONAL

NAME: _____ BIRTHDATE: _____ PHONE#: _____

ADDRESS: _____

FHRA MANAGER'S NAME: _____ PHONE#: _____

The reasonable accommodation I am requesting is: _____

_____

THIS FORM IS TO BE COMPLETED BY A QUALIFIED PROFESSIONAL SPECIALIZING IN THE AREA OF THE MEDICAL CONDITION.

1. **Medical Professional's Information**

   Name: _____

   Credentials & Specialty: _____

   Medical Facility Affiliation: _____

   Facility Address: _____

   Phone Number: _____

2. A reasonable accommodation has been requested from the individual listed above. A necessary accommodation is one that will affirmatively enhance a disable person's quality of life by ameliorating the effect of the disability. Please complete form in full, all incomplete forms will result in a denial.

   In your opinion, is it necessary for the individual to be granted the above requested accommodation in order to allow them an equal opportunity to enjoy their apartment community?
   Yes_____ No _____

3. Is there an identifiable link between the individual's disability and the reasonable accommodation in order to allow them an equal opportunity to enjoy their apartment community?
   Yes_____ No_____

4. Are there any other medical options that will serve the same purpose as the reasonable accommodation requested? Yes_____ No_____
   If yes, please explain: _____

   _____

   _____

I hereby confirm that the information provided is true to the best of my knowledge and I would be willing to testify in a court of law. Title 18, Section 1001 of the U.S. Code states that a person is guilty of a felony for knowingly and willingly making false or fraudulent statements to any department of the United States Government.

_____ _____

Printed Name and Title Date

_____ _____

Signature of Medical Provider Name of Patient: