

**FORM #2**  
**DO NOT RETYPE OR ALTER THIS FORM IN ANY WAY**  
**HEALTH CARE PROVIDER'S VERIFICATION OF NEED FOR A**  
**REASONABLE ACCOMMODATION BECAUSE OF A DISABILITY**  
**REQUEST TO INCREASED UNIT TEMPERATURE**

**SECTION A**

Applicant's Name: \_\_\_\_\_

Address: \_\_\_\_\_  
(Street Address, City, State, Zip Code)

I authorize the Health Care Provider to release the medical information requested below to the Housing Authority of the City and County of Denver ("DHA"), and any other information necessary to assess the Applicant's request for an accommodation(s).

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

**Applicant must fill in all blank lines above in this Section A, and sign on the line above and date. Then take this form to your Health Care Provider so that he/she can complete Section B below. NOTE: IF BOTH SECTIONS A AND B HAVE NOT BEEN COMPLETED, YOUR REQUESTED ACCOMMODATION WILL BE DENIED.**

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**SECTION B**

**Health Care Provider must fill in all appropriate blanks below in this Section B. Before you complete this form, please read the attached information sheet so that you clearly understand what an accommodation is and how the law defines "disabled." If a question is not applicable write "N/A" next to the question.**

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Health Care Provider's Name (please print clearly)

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Street Address

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City, State and Zip Code

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Telephone Number

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Fax Number

The person named above is an Applicant for an accommodation because of disability, and is requesting that DHA provide them with the accommodation stated in Section A above. After you have completed this form, please return it to the Applicant, so they may submit the necessary forms to DHA for their request to be considered.

1. In my opinion, the Applicant has a disability as defined below. Please check any paragraph below that applies. **(If none of these apply, please go to Question 2)**

A. A physical or mental impairment that substantially limits one or more major life activities, such as caring for one’s self, doing manual tasks, walking, seeing, hearing, breathing, learning and working.

B. A record of having such an impairment. If you check this box answer the following questions:

(i) Identify the covered entity that has a record of the Applicant having an impairment that substantially limits one or more major life activities.

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C. Is regarded as having such an impairment. If you check this box answer the following question:

(i) Identify the covered entity that mistakenly believes that the Applicant either has: 1) an impairment that substantially limits one or more major life activities; or, 2) an actual non-limiting impairment substantially limits one or more major life activities.

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2.  In my opinion this individual does not qualify as disabled as discussed above. **(Please go to the end of this form, read the certification and sign the bottom of this form.)**

3. Specifically identify the “major life activities” that are affected by the Applicant’s physical or mental impairment. How often is the listed “major life activity” performed (daily, weekly and/or monthly)?

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4. State, in detail, how the Applicant is significantly restricted in the condition, manner or duration under which he/she can perform the major life activities identified in Question 3 compared to the average person in the general population.

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5. Does the Applicant currently utilize, or have available to them, any medication, apparatus, or other corrective measures that would mitigate the disability?

YES       NO

If yes, please explain in detail: \_\_\_\_\_

\_\_\_\_\_

6. Does the Applicant have available to them any medication, apparatus, or other corrective measures that would provide a similar accommodation for the Applicant's disability (i.e., utilizing sleep aides or ear plugs to reduce disturbance by spouse during the night)?

YES       NO

If yes, please explain in detail: \_\_\_\_\_

\_\_\_\_\_

7. Is the disability permanent?

YES (Go to 8 below)     NO (Answer A below)     UNKNOWN (Answer B below)

A. If the disability is temporary, how long will the Applicant be disabled?

\_\_\_\_\_

B. If the disability status is unknown, when will the Applicant's disability status be determined? \_\_\_\_\_

\_\_\_\_\_

How long will the Applicant be disabled? \_\_\_\_\_

\_\_\_\_\_

8. In my opinion, the Applicant's disability requires an accommodation that the temperature in their unit be raised from a maximum of 72° to \_\_\_\_\_°F in order for the Applicant to have an equal opportunity to participate in, or benefit from, DHA housing programs.

YES (Please respond to each of the following questions.)

NO (Please go to the end of this form, read the certification and sign the bottom of this form.)

A. How is raising the temperature above 72° directly related to the Applicant's disability?

\_\_\_\_\_

\_\_\_\_\_

B. How will raising the temperature above 72° enable the Applicant to have an equal opportunity to participate in, or benefit from, DHA housing programs?

\_\_\_\_\_

C. Is raising the temperature from 72° medically necessary? Medically necessary is defined as procedures, treatments, supplies, devices, equipment, facilities or drugs (all services) that a medical practitioner, exercising prudent clinical judgment,

would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury or disease or its symptoms, and that are:

- in accordance with generally accepted standards of medical practice; and
- clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease; and
- not primarily for the convenience of the patient, physician or other health care provider; and
- not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

YES

NO

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**I HEREBY CERTIFY THAT I HAVE READ THE INFORMATION SHEET FOR COMPLETING THE "HEALTH PROVIDER'S VERIFICATION OF EMPLOYEE NEED FOR A REASONABLE ACCOMMODATION BECAUSE OF A DISABILITY" FORM AND I UNDERSTAND ITS CONTENTS. I FURTHER CERTIFY THAT ALL INFORMATION I PROVIDED IN THIS FORM IS ACCURATE, COMPLETE, AND CURRENT. FINALLY, I AGREE TO TESTIFY AT ANY TRIALS OR HEARINGS AS REQUIRED BY DHA AND I UNDERSTAND THAT I CAN BE SUBPOENAED TO TESTIFY IN ANY SUCH TRIALS OR HEARINGS.**

**WARNING: THERE ARE FINES AND IMPRISONMENT -- \$250,000/5 YEARS FOR ANYONE WHO MAKES FALSE, FICTITIOUS, OR FRAUDULENT STATEMENTS OR ENTRIES IN ANY MATTER WITHIN THE JURISDICTION OF THE FEDERAL GOVERNMENT (18 USC 1001). IN ADDITION, ANY PERSON WHO KNOWINGLY AND MATERIALLY VIOLATES ANY REQUIRED DISCLOSURE OF INFORMATION, INCLUDING INTENTIONAL NON-DISCLOSURE, IS SUBJECT TO CIVIL MONEY PENALTY NOT TO EXCEED \$10,000 FOR EACH VIOLATION.**

**NOTE: YOU MUST SEND YOUR RESPONSE WITH AN ORIGINAL SIGNATURE TO DHA, IN ORDER FOR DHA TO CONSIDER YOUR PATIENT'S REQUEST.**

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Signature of Health Provider (*please sign with blue ink*)

Thank you. If you have any questions, please contact the 504 Coordinator, Meichell Walsh, at (720) 932-3144; TDD (720) 932-3111; or Colorado Relay TDD (800) 659-2656; P. O. Box 40305, Mile High Station, Denver, CO 80204-0305.