

**FORM #2**

**HEALTH CARE PROVIDER’S VERIFICATION OF NEED FOR AN ACCOMMODATION IN HOUSING BECAUSE OF A DISABILITY**

**DO NOT RETYPE OR ALTER THIS FORM IN ANY WAY**

**SECTION A**

Applicant’s Name: \_\_\_\_\_

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

Requested Accommodation: \_\_\_\_\_

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.**

**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.**

\_\_\_\_\_  
Health Care Provider’s Name (please print clearly)

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State and Zip Code

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Fax Number

You need to complete this section.

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 6 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 that one or more of the following categories of accommodations be made in order for the Applicant to have an equal opportunity to participate in, or benefit from, DHA housing programs: (a) a fully accessible apartment or other physical modifications to the apartment or public/common areas, including assistive technology, (b) changes in DHA's rules, policies, practices, or services of the housing development, or DHA, as applied to Applicant, or (c) assistance with communications with DHA.

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.)

**IF APPLICANT IS REQUESTING TO RENT FROM A RELATIVE, PLEASE SKIP SUBSECTIONS A THROUGH D BELOW AND GO TO QUESTION 9.**

**IF APPLICANT REQUIRES AN EXTRA BEDROOM FOR MEDICAL EQUIPMENT, PLEASE SKIP SUBSECTIONS A THROUGH D BELOW AND GO TO QUESTION 10.**

**IF APPLICANT REQUIRES AN ASSISTANCE ANIMAL PLEASE SKIP SUBSECTIONS A THROUGH D BELOW AND GO TO QUESTION 11.**

A. Specifically identify the accommodation(s) that is/are required in order for the Applicant to have an equal opportunity to successfully live in DHA housing (i.e., be lease compliant) or to participate in DHA programs, such as Section 8.

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D. How will the requested accommodation(s) enable the Applicant to have an equal opportunity to participate in, or benefit from, DHA housing programs?

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9. If Applicant is requesting to rent a Section 8 unit from a relative, please respond to the following questions: **(NOTE: YOU MUST TIE THE NECESSITY OF RENTING THE SPECIFIC UNIT IN QUESTION TO THE INDIVIDUAL'S DISABILITY AND EXPLAIN WHY THEY ARE NOT ABLE TO FIND THE SAME ACCOMMODATION IN A UNIT THAT IS NOT OWNED BY A RELATIVE.)**

Renting from a Relative

A. Does the unit the Applicant is requesting to rent have any special features required because of the Applicant's disability?

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

B. What are the special features of the unit? Provide a detailed description of each feature.

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7. If Applicant is requesting an extra bedroom to store medical equipment, please respond to the following questions:

Medical Equipment:

A. Does the Applicant need an extra bedroom to store medical equipment or exercise equipment?

YES

NO

B. Identify the relationship, or nexus, between the Applicant's request for an additional bedroom and the Applicant's disability.

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C. Identify the relationship, or nexus, between the special features of the unit and the Applicant's disability.

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D. List all modifications made to the unit specifically designed to aid the Applicant.

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8. Federal regulations require DHA to allow, as a reasonable accommodation, a qualified person with a disability to own and keep an "assistance animal" (also referred to as a service animal or companion animal), on DHA's premises. An assistance animal is an animal that works, provides assistance, or performs tasks for the benefit of a person with a disability; or animals that provide emotional support that alleviate one or more identified symptoms or effects of a person's disability. If Applicant is requesting that they be allowed to keep an assistance animal, please answer the following questions:

Assistance Animal:

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10. If the Applicant is requesting an extra bedroom to store medical and/or exercise equipment, please respond to the following questions: **(NOTE: EXERCISE EQUIPMENT MUST BE PRESCRIBED FOR THE APPLICANT'S DISABILITY**

**AND CANNOT SIMPLY BE ANY EXERCISE EQUIPMENT THAT WOULD BE BENEFICIAL TO ANYONE'S GENERAL HEALTH.)**

Medical Equipment:

- A. Does the Applicant need medical equipment or exercise equipment that requires storage in a separate location, other than the living room, bathroom, kitchen, or Applicant's bedroom(s)?

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- C. Is the assistance animal trained to provide any specific services (e.g., dog trained to aid the visually-impaired or hearing impaired; or the dog assists an individual in a wheelchair by pulling, retrieving, or other assistance which requires the animal to be specifically trained to provide the service)?

**YES**

**NO**

- B. List all medical equipment and/or exercise equipment the Applicant has at home and the approximate size of the equipment.

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- C. Why must the Applicant store this equipment in a separate bedroom, instead of another room of the unit?

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- D. Where does the Applicant use the medical equipment or exercise equipment? How often is it used?

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- E. Identify the relationship, or nexus, between the Applicant's request for an additional bedroom, the need for the medical equipment or exercise equipment, and the Applicant's disability.

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11. Federal regulations require DHA to allow, as a reasonable accommodation, a qualified person with a disability to own and keep an “assistance animal” (also referred to as a service animal or companion animal), on DHA’s premises. An assistance animal is an animal that works, provides assistance, or performs tasks for the benefit of a person with a disability; or animals that provide emotional support that alleviate one or more identified symptoms or effects of a person’s disability. If the Applicant is requesting that they be allowed to keep an assistance animal, please answer the following questions:

Assistance Animal.

- A. Does the Applicant require an assistance animal as defined above?

**YES**

**NO**

- B. Identify the relationship, or nexus, between the Applicant’s request for an assistance animal and the Applicant’s disability.

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- C. Is the animal trained to provide any specific services (e.g., dog trained to aid the visually-impaired or hearing impaired; or the dog assists an individual in a wheelchair by pulling, retrieving; or other assistance which requires the animal to be specifically trained to provide the service)?

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- D. If the animal has not been specifically trained to provide a service, what unique skill(s) or attribute(s) does the animal have? How do these unique skill(s) or attribute(s) benefit the Applicant's disability? You must explain the skill(s) or attribute(s) the animal has, which are different or unique to the animal in question, and differ from those of a pet (i.e., most pets provide companionship).
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**I HEREBY CERTIFY THAT I HAVE READ THE INFORMATION SHEET FOR COMPLETING "FORM #2 – HEALTH CARE PROVIDER'S VERIFICATION OF NEED FOR AN ACCOMMODATION IN HOUSING BECAUSE OF A DISABILITY" AND I UNDERSTAND ITS CONTENTS. I FURTHER CERTIFY THAT ALL INFORMATION I PROVIDED IN THIS FORM IS ACCURATE, COMPLETE, AND CURRENT. FINALLY, I UNDERSTAND THAT I CAN BE SUBPOENAED TO TESTIFY IN ANY TRIALS OR HEARINGS RELATED TO THE APPLICANT'S REQUEST.**

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

**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.**

Thank you. If you have any questions, please contact the 504 Coordinator, Meichell Walsh, at (720) 932-3092; TDD (720) 932-3111; or Colorado Relay TDD (800) 659-2656; P. O. Box 40305, Mile High Station, Denver, CO 80204-0305.

*(Este es un aviso importante. Por favor hagala traducir inmediatamente.)*