



**PUBLIC HOUSING AND COMMUNITY DEVELOPMENT
REASONABLE ACCOMMODATION VERIFICATION**

Head of Household: _____ Client No: _____
(PRINT NAME)

Re: Reasonable Accommodation Request

For: _____ Telephone: _____
(PRINT NAME OF HOUSEHOLD MEMBER FOR WHOM THE REQUEST IS BEING MADE)

PLEASE RETURN TO: _____
(Name of PHCD Employee)

Address of PHCD Employee)

(Phone/Fax of Employee)

THE FOLLOWING SECTION IS TO BE FILLED OUT BY THE DESIGNATED VERIFICATION SOURCE:

- The individual seeking an accommodation is a person with a disability according to the following definition:
“Disability” is defined as 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.
 YES NO
- Describe the problem(s) that the person is having with the PHCD dwelling, building, property, practice, rule, policy, procedure, program or service:
- Describe the type of change(s), feature(s) or assistance required:
- Using the checklist on page 2 of 2, indicate the functional limitation(s) (i.e. the way major life activities are substantially limited) of the person for whom the accommodation is requested.**
- Please describe the relation between the person’s functional limitation(s) and the requested accommodation. Do not provide unnecessary details about the medical history or disabled status of the person seeking an accommodation.

Name of Verification Source: _____
(PRINT NAME OF HEALTH CARE PROVIDER)

Signature: _____ Date: _____

Title of Verification Source: _____ License Practice #: _____

Address: _____

Telephone: _____ Fax: _____

FUNCTIONAL LIMITATIONS OF CLIENT'S MAJOR LIFE ACTIVITIES CHECKLIST

CLIENT'S NAME: _____ CLIENT #: _____
Last First

TYPE OF MAJOR LIFE ACTIVITIES <i>(Check applicable)</i>	DISABILITY STATUS D= Disabled* (or) ND= Not Disabled <i>(Enter D or ND as applicable)</i>
<input type="checkbox"/> Walking	
<input type="checkbox"/> Standing	
<input type="checkbox"/> Climbing	
<input type="checkbox"/> Bending	
<input type="checkbox"/> Stooping	
<input type="checkbox"/> Kneeling	
<input type="checkbox"/> Use of Hands	
<input type="checkbox"/> Reaching	
<input type="checkbox"/> Self Care	
<input type="checkbox"/> Speaking	
<input type="checkbox"/> Breathing	
<input type="checkbox"/> Seeing	
<input type="checkbox"/> Hearing	
<input type="checkbox"/> Lifting	
<input type="checkbox"/> Intelligence (a person's capacity for understanding)	
<input type="checkbox"/> Thinking (the ability to form or conceive in the mind)	
<input type="checkbox"/> Perception (the brain's interpretation of internal and external stimuli)	
<input type="checkbox"/> Judgment (the ability to assess a given situation and act appropriately)	
<input type="checkbox"/> Mood (emotional tone underlying the behavior)	
<input type="checkbox"/> Behavior (specifically examining behavior that is disruptive, distressing or aggressive)	
<input type="checkbox"/> Other (Please Specify in non-technical terms that simply describe what the client cannot do or has difficulty doing)	
HEALTH CARE PROVIDER / VERIFICATION SOURCE INFORMATION	Print Name: _____ Date: ___/___/___ Signature: _____ Telephone #: (____) _____
NOTES (use additional sheet if necessary):	

* "Disability" is defined as a physical or mental impairment that substantially limits one or more major life activities.

Warning: Title 18, US Code Section 1001, states that a person who knowingly and willingly makes false or fraudulent statements to any Department or Agency of the United States is guilty of a felony. State law may also provide penalties for false or fraudulent statements.



This material is available in an accessible format upon request. Please call, Section 504/ADA Coordinator at 786-469-2155 or Florida Relay Service TDD/TTY 800-955-8771.

ASC/07/5110