REASONABLE ACCOMMODATION CERTIFICATION

AUTHORIZATION COMPLETED BY CLIENT

Person Requesting Accommodation	Requested Accommodation
Provider Name	Agency/Facility

Provider Type: (Title)
☐ Physician ☐ Psychiatrist ☐ Nurse Practitioner ☐ Rehabilitation Professional ☐ Social Worker ☐ Psychologist ☐ Disability Service Agency Provider ☐ Other:

CERTIFICATION / RELEASE / ACKNOWLEDGMENT

I authorize Harrisonburg Redevelopment and Housing Authority (HRHA) to contact the provider named above to verify my disability and need for my requested accommodation. I understand that this release is limited to information required to verify my request and that information obtained by HRHA will be kept confidential and used solely to make a determination on my accommodation request.

This request shall become effective immediately and shall remain in effect for 90 days.

Signature _____ Date _____

I understand that this authorization is voluntary; I can withdraw permission at any time. I understand that HRHA is not a healthcare provider, and released information will be kept confidential but is not subject to HIPAA. I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to the releasing agency. Written revocation will be effective upon receipt, but will not apply to information already released in response to authorization. I understand that once my healthcare provider discloses my information to HRHA, they are no longer responsible for its privacy. I understand that I have a right to receive a copy of this authorization for my records. Copies of this release should be treated the same as an original.

CERTIFICATION COMPLETED BY CARE PROVIDER

The person listed above has asked that you complete this certification regarding their requested accommodation, listed above:

1. What is your relationship to this person, and what qualifies you to make the assessments sought on this form? If you provide medical or other services to this person, please state how long you have done so and in what capacity.

2. In your professional opinion, does this person have a disability, defined as a physical or mental impairment that substantially limits one or more major life activities[1]; a record of such impairment; or being regarded as having such an impairment? **[ ]** Yes, permanent/long-term **[ ]** Yes, short-term (<1 year) **[ ]** No **[ ]** Not enough info

3. Is the requested accommodation necessary to allow the person equal access to use and enjoy their housing?
   [ ] Necessary **[ ]** Beneficial; not necessary (alternatives exist) **[ ]** Not beneficial; not necessary **[ ]** Not enough information to say
   Please explain the basis for your assessment; describe any alternatives, and provide any comments:

4. Would you recommend this type of accommodation for persons with similar impairments? **[ ]** Yes **[ ]** No *(explain)*

5. Would you be willing to testify on the patient's behalf to the information provided on this form? **[ ]** Yes **[ ]** No

I certify that it is my professional opinion that the above-named person has a qualified disability that has a verifiable need for accommodation. I certify my professional opinion is in compliance with applicable laws, regulations, standard industry practices and licensing guidelines.

Signature _____ Name _____ Date _____

Address _____ Title _____ Phone _____

[1] Major life activities include caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working