Verification of Status of Person with a Disability

Montana Housing Transactions – Reasonable Accommodation /Modification

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HOUSING ACCOMMODATION VERIFICATION FORM

Date:

RECIPIENT INFORMATION

Name of housing provider/landlord/property manager/housing authority:

Mailing address:

City: **State:**

Zip:

RESIDENT / APPLICANT INFORMATION

Name of resident/applicant/household member requesting accommodation or modification:

Housing unit or property address:

City: **State:**

Zip:

PURPOSE OF VERIFICATION

The individual identified above has requested a reasonable accommodation or modification related to a disability. Under federal fair housing laws, housing providers are required to allow reasonable accommodations or modifications when necessary for a person with a disability to have an equal opportunity to use and enjoy a dwelling.

DEFINITION OF DISABILITY

Under federal law, a disability generally includes: (a) a physical or mental impairment that substantially limits one or more major life activities; (b) a record of such an impairment; or (c) being regarded as having such an impairment.

EXAMPLES OF IMPAIRMENTS

Examples of physical or mental impairments include, without limitation, conditions affecting: neurological or musculoskeletal systems; respiratory or cardiovascular systems; sensory organs (such as vision or hearing); and mental or psychological conditions. This verification does not require disclosure of a specific diagnosis.

IMPORTANT NOTICE TO VERIFYING PROFESSIONAL

You are not required to disclose the nature, severity, diagnosis, or detailed medical history of the disability. The purpose of this verification is solely to confirm that the individual meets the legal definition of disability and that the requested accommodation or modification has a disability-related need.

PROFESSIONAL VERIFICATION

I am a qualified professional (for example, physician, psychologist, licensed clinical social worker, therapist, case manager, or other qualified medical or social service professional) with knowledge sufficient to make the determinations below.

By initialing each statement that applies and signing below, I verify:

(initials) **The individual identified above is a person with a disability within the meaning of applicable federal fair housing laws.**

(initials) **The requested accommodation or modification described below is necessary or consistent with the needs associated with the individual's disability to afford equal opportunity to use and enjoy the dwelling.**

DESCRIPTION OF REQUESTED ACCOMMODATION OR MODIFICATION

DURATION OF DISABILITY

If known, expected duration or permanence of the disability:

IMPACT ON MAJOR LIFE ACTIVITIES (IF APPROPRIATE)

List major life activities substantially limited:

SIGNATURE OF VERIFYING PROFESSIONAL

PROFESSIONAL SIGNATURE

SIGNATURE:

PROFESSIONAL DATE

Date:

Printed name and professional title:

Organization or employer:

Mailing address:

City: **State:**

Zip:

Phone: **Email:**

Professional license number and state (if applicable):

NOTICE REGARDING TIME CALCULATIONS

Unless otherwise specified, the term "days" refers to calendar days. If a deadline falls on a weekend or legal holiday, it may be completed on the next business day.

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