GAINESVILLE HOUSING AUTHORITY
Where Housing Matters

1900 SE. 4th St., Gainesville, FL 32641
Telephone (352) 872-5500 ~ Fax (352) 872-5501
www.gainesvillehousingauthority.org

EXECUTIVE DIRECTOR
PAMELA E. DAVIS

CERTIFICATION OF NEED FOR REASONABLE ACCOMMODATION

THIS FORM MUST BE COMPLETED BY A QUALIFIED MEDICAL, REHABILITATION OR OTHER NON-MEDICAL SERVICE AGENCY PROFESSIONAL WHOSE FUNCTION IS TO PROVIDE SERVICES TO THE DISABLED AND MAY VERIFY THE NEED.

(Please be sure to answer all applicable questions on this form)

Head of Household: _____

Household Member who needs Accommodations: _____

Address (including unit #): _____

Daytime Phone: (___) _____ Cellular Phone: (___) _____

Daytime Phone: (___) _____ Message Phone: (___) _____

The above household member is applying for a reasonable accommodation at the Gainesville Housing Authority (GHA) and is requesting that you, as his/her provider, fill out the following certification .Enclosed is a copy of the ***Request for Reasonable Accommodation form*** with his/her signature for the release of information.

1. Please indicate how current your knowledge is requiring this individual:

   ( ) Within the last 6 months ( ) Over the last 6 months ( ) Other (please explain)

Please check only those that apply:

2. In my opinion, the Applicant/Resident has a disability as defined below:

   ( ) **YES** (please continue)

   ( ) **NO** (please proceed to page 4, sign and return to the address listed on the top of the page)

   A) _____ A physical or mental impairment that substantial limits one or more major life activities;

   B) _____ A record of having such an impairment;

   C) ____ Is regarded as having such impairment.

NOTE: The following information is requested solely for the purpose of identifying the unit of the most appropriate size, type and design for the applicant/resident and will not be used for any other purpose. The GHA will make every effort to make the appropriate modifications or identify an appropriate unit based on your professional opinion outlined herein. If a transfer to another unit is the only solution, a unit will be assigned to the resident when the resident reaches the top of the Transfer Waiting List and when such a unit that matches his/her criteria becomes available. **Certain requested features may inhibit an exact match and/or increase the applicant/resident's time on the waiting list, so please check only those accommodations that are necessary.** The GHA will contact applicant/residents when this occurs to offer options and assist in problem-solving alternatives.

3. In my opinion, the Applicant's/Resident's disability **does not require** a wheelchair accessible unit but **does require other physical modifications to the apartment or common areas, including assistive**

technology in order for the Applicant/Resident to have equal opportunity to live successfully in GJA housing.

( ) **YES** (Please describe all the special features this applicant/resident needs and indicate or check off all that apply below. Please remember that in order show that a requested accommodation may be necessary, there must be an identifiable relationship, or nexus, between the requested accommodation and the individual's disability.)

Maximum # of stairs may climb to unit: _____ Maximum # of steps may walk to elevator: _____

Maximum floor location: _____ First floor or Elevator: _____

( ) **NO** (Please continue)

Please describe any other special housing features, types of physical adaptation and/or assistive technology (i.e. flashing doorbell, flashing timer on stove, no more than 3 consecutive stairs, etc.) that are **necessary** as a result of his/her disability in order for him/her to enjoy an equal housing opportunity, please **print clearly** and explain why the accommodation(s) is/are required:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Also, please indicate, if applicable and if you have such information, where any specialized equipment may be obtained:

_____

_____

_____

_____

_____

4. In my opinion, the Applicant/Resident's disability **does require** that a **wheelchair accessible** apartment be made available to the household:

( ) **YES** (Please describe all the **necessary** requirements this applicant/resident needs and **check below only** those that apply. Please remember that in order to show that a requested accommodation may be necessary, there must be an identifiable relationship, or nexus, between the requested accommodation and the individual's disability):

( ) Door Width >32" ( ) Kitchen Turn>5' ( ) Hall Radius>5' ( ) Roll-Under Stove

( ) *Roll-Under Sink ( ) Tub Grab Bars ( ) Toilet Grab Bars ( ) Handheld Shower

( ) *Roll-In Shower ( ) *Side-by-Side Refrigerator

Note: *The number of units with these features is limited therefore the wait **may** be longer.

( ) **NO** (please continue)

In addition, the following features, not captured above or on the previous page, are **necessary** for the Applicant's/Resident's wheelchair accessible unit. If additional unit space is required explain in detail why and provide the equipment and/or room measurements.

_____

_____

_____

_____

_____

5. In my opinion, the Applicant/Resident **does not need any physical changes or modification to an apartment,** but an accommodation in rules or a change in a policy or procedure **is necessary** as a direct result of his/her disability in order to enjoy an equal housing opportunity.

( ) **YES** (please describe i.e. needs to be specific location and why; near a specific healthcare facility; or needs **24-hour or overnight live-in personal care attendant** to provide what specific duties. If your agency will provide the personal care attendant, or if a family member is identified, is that individual qualified per your professional opinion? Provide the complete name of the identified personal care attendant):

_____

_____

_____

_____

_____

( ) **NO** (please continue)

(**Please be sure to answer all applicable questions on this form.)**

6. Based on your professional opinion, you (**Please check only one of the following)**

( ) **Certify** that the enclosed request for the changes to the apartment or common area or to the rules, policies and procedures is necessary for the Applicant/Resident, as a result of his/her disability in order to have an equal housing opportunity.

( ) **Cannot certify** that the enclosed request is necessary for the changes to the apartment or to the rules, the policies and procedures for the Applicant/Resident, as a result of his/her disability in order to have equal housing opportunity.

OR

( ) **Do not believe** the Applicant/Resident needs a change to the apartment or common area or to rules, policies or procedures, as a result of his/her disability in order to have an equal housing opportunity.

_____ _____ _____

Name (Please print clearly) Signature Today's Date

_____ _____
Title of medical or rehabilitation professional or expert Agency or Clinic, if applicable

(__)_____ (__)_____
Telephone # Fax #

Please return form to:
Gainesville Housing Authority

Attention: _____

Address: 1900 SE 4th Street

City/State/Zip: Gainesville, FL 32641

Fax: (352) 872-5501 (**Original must be mailed)**

Warning: Section 1001 of Title 18 of the US Code makes it a criminal offense to make any willful false statements of misrepresentations to any Department or Agency of the United States as to any matter within its jurisdiction, punishable by fine not to exceed $250,000 and/or imprisonment of not more than 5 years