COLUMBUS METROPOLITAN HOUSING AUTHORITY
COMMUNITY. COMMITMENT. COLLABORATION.

CMHA 504-REASONABLE ACCOMMODATION REQUEST/VERFICATION FORM

Applicant/Tenant must fill in all blank lines below.

_____

Applicant/Tenant's Name

_____

Street Address, City, State, Zip Code

_____

Email address **Phone Number**

_____

Date of Request

CMHA makes reasonable adjustments to its rules, policies, practices, or services when such accommodations may be necessary to afford a tenant or applicant with a physical or mental disability the equal opportunity to use and enjoy a dwelling unit, including public and common use areas, including the use of service or assistance animals

Title II of the Americans with Disabilities Act (§ 35.108) defines a disabled person as:

(a) a person who has a physical and/or mental impairment that substantially limits one or more major life activities and is a person who has a history or record of such an impairment or a person who is regarded as having such an impairment. (i) As used in this definition, "a physical and/or mental impairment" includes any physiological disorder or condition, cosmetic disfigurement, anatomical loss, and any mental or psychological disorder. (ii) "Major life activities" includes functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working. (b) Disabilities do not have to be permanent or have existed for a period of time before a reasonable request is made.

Requested Accommodation:_____

_____

_____

_____

Applicant/Tenant's Signature **Date**

IF YOU ARE REQUESTING AN ADDITIONAL BEDROOM FOR MEDICAL EQUIPMENT, YOUR MEDICAL PROVIDER MUST SPECIFICALLY DESCRIBE THE EQUIPMENT AND THE APPROXIMATE SIZE OF THE EQUIPMENT. ANY REQUEST THAT DOES NOT PROVIDE THAT INFORMATION WILL BE RETURNED TO THE MEDICAL PROVIDER FOR FURTHER PROCESSING AND/OR DENIED.

By signing this form, I authorize the health care provider listed on the form below to provide CMHA with information to make a decision regarding my request for a reasonable accommodation.

NOTE: IF THIS PAGE HAS NOT BEEN COMPLETED, YOUR REQUESTED REASONABLE ACCOMMODATION MAY BE DENIED. IF THE FOLLOWING PAGE HAS NOT BEEN COMPLTED AND RECEIVED WITHIN (30) CALENDAR DAYS OF THE DATE OF THE PROVIDER LETTER, THE REQUESTED ACCOMMODATION MAY BE DENIED.

Health Care Provider must fill in all appropriate blanks in the section below. DO NOT ATTACH ANY MEDICAL RECORDS OR OTHER DOCUMENTATION REGARDING THE INDIVIDUAL'S DISABILITY. You must address these issues in your answer to the questions below. CMHA cannot and will no interpret documentation regarding an individual's disability to determine if their disability requires the requested accommodation. As the Health Care Provider, it is your responsibility to provide the necessary information regarding the individual's disability and how that disability is related to their Request for Accommodation.

Verification Questionnaire

The tenant/applicant identified above has requested a reasonable accommodation from CMHA. So that CMHA can process this request, please answer the following questions and return this completed form to CMHA

1. **Is the individual identified above disabled, as the term has been defined above?____Yes____No**
2. **Is this individual under your care as a Health Care provider?____Yes____No**
3. **Under your health care, have you seen this individual within the last 12 months?____Yes____No**
4. **How long have you been treating this individual? In your response, please do not include any details of the treatment. _____**
5. **Please provide your professional credentials that support your ability to assess whether the individual has a disability. _____**

   _____
6. **Does the Applicant/Tenant have disability that requires a Reasonable Accommodation?**
   ____Yes No

   If yes, please describe how the requested accommodation will enable the individual equal opportunity to use and enjoy a dwelling unit, including public and common use areas. *There must be an identifiable relationship, or nexus, between the requested accommodation and the individual's disability. Please only provide information that is necessary to evaluate the disability-related need for the accommodation. The nature or extent of the disability is not required.*

   _____
   _____
   _____
7. **The 504-Reasonable Accommodation will provide health and/or supportive care services as follows (if requesting a second bedroom for medical equipment, include approximate physical dimensions of required medical equipment):**

   _____
   _____
   _____
   _____
   _____

I HEREBY CERTIFY THAT ALL INFORMATION THAT I PROVIDED IN THIS FORM IS ACCURATE, COMPLETE, AND CURRENT. I UNDERSTAND THAT I CAN BE SUBPOENAED TO TESTIFY IN ANY TRIALS OR HEARING RELATED TO THE APPLICANT/TENANT'S REQUEST. I ALSO ACKNOWLEDGE THAT SECTION 1001 OF TITLE 18, UNITED STATES CODE, MAKES IT A CRIMINAL OFFENSE TO MAKE AN KNOWING AND WILLFUL FALSE STATEMENT TO ANY DEPARTMENT OR AGENCY OF THE UNITED STATES AS TO ANY MATTER WITHIN ITS JURISDICTION, PUNISHABLE BY A FINE NOT TO EXCEED $250,000.00 AND/OR IMPRISONMENT OF NOT MORE THAN 5 YEARS.

Health Care Provider's Name (Please Print Clearly)

Street Address

City, State, and Zip Code

Telephone Number **Fax Number**

Signature of Health Care Provider (Please Sign with Blue Ink) **Date**

Thank You.

PLEASE RETURN THIS COMPLETED FORM TO:

504-REASONABLE ACCOMMODATION COORDINATOR
Shauntae Greene
Columbus Metropolitan Housing Authority
880 East 11th Avenue
Columbus, Ohio 43211-2771
Fax: (614) 421-4516

Please contact Danielle Macon for any questions or updates:

614-340-4326 or
504accom@cmhanet.com