**THE HOUSING AUTHORITY OF THE CITY OF GREENWOOD, MS**

**POST OFFICE BOX 1847**

**111 E. WASHINGTON STREET**

**GREENWOOD, MISSISSIPPI 38935-1847**

***TELEPHONE (662) 453-4822***

***FAX (662) 455-3547***

***E-Mail: GreenwoodMSPHA@yahoo.com***

**VERIFICATION OF NEED FOR REASONABLE ACCOMMODATION**

Dear Knowledgeable Professional or appropriate party:

The individual listed below considers him or herself to be disabled and has asked for an accommodation from this agency to meet certain needs he or she believes are dictated by the disability. The Housing Authority of the City of Greenwood, Mississippi (GHA) grants reasonable accommodation requests based in part by verification of need from a knowledgeable professional or other appropriate party who has direct experience with an individual's disability. You have been

authorized to release information to us regarding the need for an accommodation.

Please be aware of the following while completing this request:

* Do not send us the medical records of the individual requesting your verification.
* Do not include any details, which disclose the nature or severity of the individual's disability. This information is not necessary to verify the requested adjustment.

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| **PART I. HOUSEHOLD MEMBER INFORMATION ˜ INSERT NAME OF INDIVIDUAL SEEKING VERIFICATON** | | |
| LAST NAME | FIRST NAME | MIDDLE INITIAL |
| ADDRESS | | |
| CITY | STATE | ZIP CODE |

I, authorize

**(Applicant/Resident/Participant's Name) (Knowledgeable Professional)**

to disclose relevant information to GHA regarding the need for a reasonable accommodation for

. I understand the information that GHA obtains will be kept confidential and used solely to determine if an accommodation should be provided

***Signature of Applicant/ Resident/Program Participant Date***

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| **PART II. DISABILITY VERIFICATION** |

Name of individual seeking verification:

A "disability" is defined as a physical or mental impairment, which limits one or more of a person's major life activities, a record of having such an impairment, or being regarded as having such impairment.

1. Does this individual have a disability, as defined above? Yes\_\_ No \_
2. If yes, does this individual, because of this disability, need a reasonable accommodation made to either their unit, or other parts of the housing complex, or to house rules, policies, practices, or services of the GHA to have an equal opportunity to use and enjoy his or her dwelling? Yes\_\_\_ No\_\_\_
3. If yes, please describe the accommodation needed (which must directly relate to the accommodation request and disability. Changes must be necessary, NOT only desirable):

Use separate sheet to provide additional information **(please print clearly)**

1 Major life activities include, but are not limited to performing tasks, caring for oneself, walking, talking, seeing, hearing, breathing, learning, or working.

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| **PART III. ACCOMMODATION VERIFICATION** |
| Patient's disability requires a reasonable accommodation for the following reasons, please complete the below information. Knowledgeable Professional please initial all that apply.  Requesting patient needs their own bedroom Yes No  Initials  Live in Aid Full time\_\_ Part time Intermittent\_\_\_\_ If, Intermittent please explain (Initials)  Care Provider \_\_\_\_\_Full time \_\_\_ Part time \_\_\_\_ Additional bedroom for Live in Aid Yes\_\_\_\_\_ No**\_\_\_\_\_**  (Initials) (Initials)  Additional bedroom for medical equipment/supplies Yes \_\_\_\_ No \_\_\_\_\_  List equipment/supplies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (Initials)  Downstairs unit Yes No (Initials) |
| **PART IV. VERIFIER’S STATEMENT** |
| **Verifying Person's Signature** |
| **Verifying Person's Name (Print)** |
| **Title:** |
| **Agency/Business** |

Please return completed, signed and dated form to:

Agency: Address:

Phone: Fax:

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**111 E. Washington Street**

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