Baltimore County Office of Housing
REASONABLE ACCOMMODATION VERIFICATION FORM

Part A: To be completed by head of household- Please print

1. Name of Head of Household: _____
2. Name of person in the household with disabilities for whom you are requesting the reasonable accommodation(s): _____
   Please write the name of the ONE person in household with the disability that requires the specific reasonable accommodation below. If more than one household member requires a reasonable accommodation, a separate Request and Verification Form will be required.
3. Please state the exact reasonable accommodation(s) listed on the Reasonable Accommodation Request Form that you are requesting for this person:
   _____
   _____

Signature of Head of Household*: _____ Date: _____

Signature of person for whom the accommodations are being requested (if over 18) *:

_____ Date: _____

The signature(s) above authorize(s) the evaluator/diagnostician to provide answers to the questions below to the best of his/her knowledge.

Please provide the Evaluator/Diagnostician with BOTH pages of this form. Do not write below this line or on page 2.

Part B: To be completed by the Evaluator/Diagnostician.

The evaluator/diagnostician shall be a person with appropriate credentials and current knowledge of the participant's or applicant's disability who is able to make an informed judgement based on that knowledge, such as a medical provider, social service agency, disability agency, clinic, or other professional evaluator/diagnostician or treatment provider. The evaluator/diagnostician must confirm the medical need for the requested reasonable accommodation.

Dear Evaluator/Diagnostician:

The Baltimore County Office of Housing (BCOH) provides reasonable accommodation to individuals with disabilities who have a disability related need for the accommodation. A reasonable accommodation is an exception made to the usual rules or policies that may be necessary for the participant due to a disability. Examples may include: receiving information in alternative format, providing interpreter services, modifying a housing unit (e.g., grab bars, raised toilet, etc.), transferring to another unit, live-in aide, etc.

The individual identified in Part A of this form has authorized you to provide verification in support of their current request listed in Part A. Please complete the information in Part B on page 2. Thank you for your assistance in completing this form. The information obtained will be kept confidential and used solely by BCOH to determine the need for the specific accommodation(s) listed in Part A.

Please refer to #3 of Part A as to the specific accommodation(s) being requested for the specific household member also named in #2 of Part A. If you were not provided with Part A, please do not complete the form.

1. In my opinion, the individual named in #2 of Part A has a disability as defined below. ☐**YES** ☐**NO**

Select one or more of the following:

A) ☐ A physical or mental impairment that substantially limits one or more major life activities;

B) ☐A record of having such an impairment, or;

C) ☐ Is regarded as having such an impairment.

2. I verify that the requested accommodation(s) named in #3 of Part A is/are directly related to the individual's disability and may be necessary to access housing services, maintain housing or fully use or enjoy their housing. I recommend that the request for accommodation as described on page 1 be approved.

☐**YES** ☐**NO** If no, please explain: _____

3. Please explain why the individual needs the specific requested accommodation(s) requested in #3 of Part A and describe specifically how the requested accommodation(s) will enable the individual to have the opportunity to access housing, maintain housing, or fully use/enjoy housing and/or any programs offered by BCOH. If in your professional opinion the individual does not require the requested accommodation(s), please explain. Please print.

_____
_____
_____
_____

_____ _____

Print Name & Position of Evaluator/Diagnostician **Signature of Evaluator/Diagnostician***

_____ _____

Date **Telephone Number**

_____

Name of practice/clinic/agency

_____

Address of Evaluator/Diagnostician' practice/clinic/agency

_____

Email address for Evaluator/Diagnostician if additional information is needed.

*Warning: Section 1001 of Title 18 of the U.S. Code makes it a criminal offense to make willful false statements or misrepresentations to any Department or Agency of the United States as to any matter within its jurisdiction.

Please be mindful that all information obtained and submitted by the household must be true and complete and the members of the family must not commit fraud, bribery or any other corrupt or criminal act in connection with the programs. See 24 CFR § 982.551 - Obligations of participant.

EQUAL HOUSING OPPORTUNITY