

Colony/Jo Don
REASONABLE ACCOMMODATION REQUEST

DATE: _____

TO: Landlord
Colony/Jo Don MHCs
5250 N US Hwy 89
Flagstaff, AZ 86004

RE: REQUEST FOR A REASONABLE ACCOMMODATION

APPLICANT'S NAME: _____ (“Applicant”).

ADDRESS: _____

I, the Applicant, am requesting that the Landlord above reasonably accommodate my disability by (state the nature of the accommodation you are requesting):

I hereby authorize my social worker, nurse, doctor, or another licensed medical provider to fill out the **Medical Verification For A Reasonable Accommodation Form** (or to supply their own letter or form addressing the information requested) so the Landlord can evaluate my request to accommodate my disability.

With respect to any accommodation request involving an assistance animal, I hereby accept and acknowledge that if the accommodation is granted I will still be responsible for complying with the requirements under the Landlord’s governing documents and applicable law regarding controlling my animal, cleaning up after my animal, reimbursing the Landlord for any damage caused by my animal, and ensuring that my animal does not make excessive noise or create a nuisance that may disturb others.

APPLICANT'S SIGNATURE: _____ **DATE:** _____

For Landlord’s Use Only:

The request for an accommodation is:

- ☐ Granted as requested above.
- ☐ Granted, but with the following modifications: _____
- ☐ Denied. Basis for Denial: _____

Name of Landlord or Manager: _____

Signature: _____

Date: _____

MEDICAL VERIFICATION FOR A REASONABLE ACCOMMODATION FORM

(To be completed by a knowledgeable professional, such as a licensed social worker, nurse, doctor, or another licensed medical professional responsible for services related to the disability of the person requesting the accommodation)

The person/applicant, below, has requested that their landlord provide a reasonable accommodation, and has asked that you, as a knowledgeable professional, verify the need for the reasonable accommodation. Please provide, below, only information that is directly relevant to the request for reasonable accommodation (i.e., documentation demonstrating that a disability which creates the need for a specific accommodation, exists).

Name of Person/Applicant Requesting the Accommodation: _____

Accommodation Requested: _____

Under Federal Law (42 U.S.C. Section 3602(h)) for the purpose of reasonable accommodation, a person has a disability if they a). have a physical, mental, or emotional impairment that substantially limits one or more major life activities, such as caring for oneself, or performing manual tasks, b). has a record of such an impairment, or c). is regarded as having such an impairment.

The term “physical or mental impairment” includes, but is not limited to, such diseases and conditions as orthopedic, visual, speech, and hearing impairments, cerebral palsy, autism, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, Human Immunodeficiency Virus infection, mental retardation, emotional illness, drug addiction, and alcoholism.

This definition does not include current, illegal use of or addiction to a controlled substance (as defined in Section 802 of Title 21).

Does the person above meet the foregoing definition of disabled? ☐ Yes ☐ No ☐ Unable to Verify

Please answer the following questions to provide the landlord with more information on the status, needs, and request for accommodation of the individual above.

Note- for an accommodation to be considered, there must be a connection between the disability and the requested accommodation. Please explain how the request is made necessary by the person’s medical condition/disability and please answer all questions below as they will allow the landlord to review and make determinations on the type of accommodation requested.

What is the anticipated duration of the disability: ☐ Permanent ☐ Not Disabled
☐ Temporary- Expected Duration: _____

Does the individual require in-home assistance for their care and well-being? ☐ Yes ☐ No ☐ Unable to Verify

If yes, please explain, including how the assistance is linked to the person’s disability: _____

What duration of assistance in the home does the applicant require: ☐ Occasional Care ☐ Live-in Care

If the requested accommodation relates to an **assistance animal**, does the animal provide disability-related assistance or emotional support? ☐ Yes ☐ No ☐ Unable to Verify

Has the individual requested any other accommodation? ☐ Yes ☐ No ☐ Unable to Verify

If yes, please explain what is requested and how it is made necessary by the person's medical condition/disability:

Additional Information. Please provide any additional information you deem directly relevant to this Verification:

Verification:

I certify that I am qualified to assess, diagnose, or treat this type of disability and that I can attest personally to the diagnosis of this disability and/or disability-related need.

I verify that this reasonable accommodation is necessary for my patient/client for the following reasons (select all that apply):

- ☐ Alleviate disability-related symptoms. ☐ Provide essential services.
- ☐ Allow for continued health and stability. ☐ Enable my patient/client to live more independently.
- ☐ Improve physical, emotional, or psychological function. ☐ Provide mobility support.
- ☐ Other _____

I attest that I am available to answer questions the landlord may have concerning this verification and my patient/client's accommodation request.

Date: _____

Name of Person Completing this Verification (Printed): _____

Signature: _____

Licensing or Professional Credentials: _____

Firm/Organization: _____

Address: _____

Phone: () _____