REQUEST FOR VERIFICATION FROM A THIRD PARTY CONCERNING A REASONABLE ACCOMMODATION OR MODIFICATION

«INSERT DATE»
«INSERT NAME OF PROVIDER»
«INSERT ADDRESS»
«INSERT CITY, STATE ZIP»

Dear Health Care Provider, Social Service Provider, or Other Qualified Person:

Cambridge Housing Authority (CHA) is a provider or affordable housing benefits to low-income families within the City of Cambridge. Since there is a shortage of funding available to meet the high demand for CHA’s housing and services, CHA must be careful in managing its limited financial resources. Providing housing accommodations or modifications often comes with an associated cost, which can be significant and can adversely impact CHA’s ability to provide affordable housing benefits to other needy families.

«INSERT APPLICANT/RESIDENT/EMPLOYEE NAME» (Requestor) is an applicant, resident, or participant of CHA. He/she has informed CHA that he/she is disabled and, as an accommodation to his or her disability, has asked CHA to make an exception to its rules or practices or to pay for a certain modification to his/her apartment. Before CHA can respond, we need to fully understand the request and verify information.

Requestor has listed you as someone who can assist CHA with information relevant to his/her request. Enclosed is a copy of his/her Request for Accommodation which includes an Authorization for you to provide information to CHA for this purpose.

IMPORTANT: In most cases, it is not necessary for CHA to know Requestor’s specific disability or impairment. Please do not identify Requestor’s specific disability, condition, treatment, medications, etc. It is only necessary for you to: 1) attest to the fact that Requestor’s impairment meets the definition of disability provided to you on page two, 2) describe the functional limitation(s) of Requestor’s disability as it pertains to his/her housing needs, 3) explain the nexus between the disability and the request, and 4) advise whether there are any less costly alternatives to what Requestor has requested.

Please answer ALL of the questions on the following pages. Please use additional pages if necessary. When you are done, please return the complete form to the individual at the address below so that CHA can process the request:

Cambridge Housing Authority
Attention: « Insert Name »
675 Massachusetts Avenue
Cambridge, MA 02139

If you have any questions, you may call me at: «Insert phone number». If I have additional questions, I may call you as well.

Thank you for your assistance.

__________________________
CHA Staff Signature

__________________________
CHA Staff Name

__________________________
Title
Name of Individual for whom accommodation/modification is being requested: ________________________________

For each question below, please do not identify Requestor’s specific disability, condition, treatment, medications, etc.

1. **How Well Do You Know the Requestor?**
   Please describe the nature and extent of your knowledge about the Requestor named above and why you are qualified to make the assessments about him or her that this form seeks. If you provide medical or other services to the person, please state how long you have done so and in what capacity.

2. **Assessment of Requestor’s Disability.**
   Not every impairment rises to the level of a “disability.” Below is the legal definition of disability which CHA lawfully is required to use in resolving this request. Please read the definition and check one of the boxes below to indicate your professional assessment as to whether or not the person meets the legal definition of a person with a “disability” under the following definition:

   A person with a disability includes any person who has a physical or mental impairment that substantially limits one or more major life activities. **Important:** the term does not include any individual who is an alcoholic or drug abuser whose current use of alcohol or drugs prevents the individual from participating in the program or activity in question, or whose participation, by reason of such current alcohol or drug abuse, would constitute a direct threat to property or the safety of others.

   (a) Physical or mental impairment includes, but may not be limited to:

   (1) Any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: Neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive; digestive; genito-urinary; hemic and lymphatic; skin; and endocrine; or

   (2) Any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities. 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, mental retardation, emotional illness, drug addiction and alcoholism.

   (b) Major life activities means functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working, among other functions.

   **YOUR PROFESSIONAL ASSESSMENT:**

   □ I do not have enough information or training to make this assessment.

   □ The Requestor IS disabled under this definition. The following major life activities are limited by a disability.  Describe the nature and extent of limitations.

   □ The Requestor IS NOT disabled under this definition.
3. **Assessment of Necessity for First Request.**
The Requestor is requesting the accommodation/modification(s) listed below. For each requested accommodation, please indicate your professional opinion whether the accommodation/modification is **medically necessary** to allow the person equal access to CHA’s housing services due to the functional limitations of his/her disability. (If there are additional requests, please see subsequent pages).

<table>
<thead>
<tr>
<th>Requested Accommodation/Modification Number 1:</th>
<th>&lt;INSERT INFORMATION&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Check Only One:</strong></td>
<td></td>
</tr>
<tr>
<td>□ Request is Medically Necessary</td>
<td>□ Beneficial but NOT Medically Necessary</td>
</tr>
<tr>
<td>□ Beneficial but NOT Medically Necessary</td>
<td>□ NOT Beneficial; NOT Medically Necessary</td>
</tr>
<tr>
<td>□ Lack Enough Information to Respond</td>
<td></td>
</tr>
</tbody>
</table>

Given CHA’s need to be fiscally responsible, are you aware of any **less costly alternatives** to what the Requestor has requested that could suffice to meet the Requestor’s medical needs?

- □ Yes, there are less-costly alternatives
- □ No, there are not less-costly alternatives
- □ I need the following additional information in order to form an opinion:

Please explain:

**Explain Basis for your Assessment/Comments:**

**Would you be willing to testify in court, if necessary, as to the representations that you have made on this Form?**
- □ Yes
- □ No

If No, please explain:

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**NOTE:** Section 1001 of Title 18 of the United States Code makes it a criminal offense to knowingly and willfully provide a materially false statement or representation on this form.

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**AFFIRMATION AND SIGNATURE**

I SOLEMNLY AFFIRM under the penalties of perjury that the information that I provided on this Form is true and correct to the best of my knowledge, information, and belief.

---

Signature

Print Name

Title

Organization

Address  City  State  Zip Code  Telephone
4. **Assessment of Necessity for Second Request:**
The Requestor is requesting the accommodation/modification(s) listed below. For each requested accommodation, please indicate your professional opinion whether the accommodation/modification is medically necessary to allow the person equal access to CHA’s housing services due to the functional limitations of his/her disability.

<table>
<thead>
<tr>
<th>Requested Accommodation/Modification Number 2:</th>
<th>&lt;&lt;INSERT INFORMATION&gt;&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Check Only One:</strong></td>
<td></td>
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Given CHA’s need to be fiscally responsible, are you aware of any less costly alternatives to what the Requestor has requested that could suffice to meet the Requestor’s medical needs?

- [ ] Yes, there are less-costly alternatives
- [ ] No, there are not less-costly alternatives
- [ ] I need the following additional information in order to form an opinion:

 Please explain:

**Explain Basis for your Assessment/Comments:**

Would you be willing to testify in court, if necessary, as to the representations that you have made on this Form?

- [ ] Yes
- [ ] No

If No, please explain:

**NOTE:** Section 1001 of Title 18 of the United States Code makes it a criminal offense to knowingly and willfully provide a materially false statement or representation on this form.

**AFFIRMATION AND SIGNATURE**

I SOLEMNLY AFFIRM under the penalties of perjury that the information that I provided on this Form is true and correct to the best of my knowledge, information, and belief.

________________________________________________________________________
Signature

________________________________________________________________________
Print Name

________________________________________________________________________
Title

________________________________________________________________________
Organization

________________________________________________________________________
Address  City  State  Zip Code  Telephone