Greene Metropolitan Housing Authority
538 N. Detroit Street, Xenia, OH 45385
Xenia: 937-376-2908, Fairborn: 937-429-7736
General Fax: 937-376-2487, Public Housing Fax: 937-347-1235, Section 8 Fax: 937-347-1230
Website: www.gmha.net

Authorization

I/we authorize GMHA to verify that the referenced Household Member has a disability and needs the reasonable accommodation(s) requested. To verify this information, GMHA may contact the below-named physician, psychiatrist, licensed psychologist, licensed nurse-practitioner, licensed social worker, rehabilitation professional or non-medical service agency whose function is to provide services to persons with disabilities. I understand the information GMHA obtains will be kept completely confidential and used solely to evaluate the request.

This authorization is requested because third-party verification may be needed. Be advised that you may submit any supporting documentation directly to GMHA rather than having GMHA contact your provider, in order to evaluate your request.

Name of Provider: ______________________________

Field of Practice: ______________________________

Agency/Clinic/Facility: ______________________________

Address: ______________________________

____

Phone: ____________________ Fax: ____________________

______________________________ ____________________
Signature of Head of Household or authorized Guardian Date

Please return this forms as promptly as possible so GMHA may make a determination on this request.

Please return to:

____________________Housing Manager ____________________email

____________________Phone Number ____________________ Fax Number

Greene Metropolitan Housing Authority
Certification of Need for Reasonable Accommodation
Section 8 Housing Only

THIS FORM MUST BE COMPLETED BY A PROFESSIONAL WHO IS COMPETENT TO RENDER A QUALIFIED OPINION, AND WHO IS KNOWLEDGABLE ABOUT THE SITUATION IN ORDER TO VERIFY THE NEED FOR A REASONABLE ACCOMMODATION FOR A HOUSEHOLD MEMBER.

PLEASE BE SURE TO ANSWER ALL APPLICABLE QUESTIONS ON THIS FORM.

Head of Household: ____

Household Member who needs an accommodation: ____________________________

Address: ___________________________________ City/Zip: ____________

Please check only those that apply:

1. In my professional opinion and assessment:

   ☐ The Household Member has a disability based on one or both of the following legal definitions. **Do not disclose nature or extent of the disability, or medical diagnosis.**

      ☐ He/she has a physical, mental or emotional impairment that limits one or more major life activities; or

      ☐ He/she has a record of having such an impairment.

   ☐ The Household Member requesting the accommodation(s) does NOT have a disability.

PART I. CHANGES TO RULES/POLICIES DUE TO DISABILITY

IMPORTANT: Only fill out this section if the disabled Household Member needs changes to rules, policies, or procedures due to his/her disability. Otherwise, please proceed to Part II.

☐ The Household Member needs a **change in a policy or procedure as a direct result of his/her disability** in order to enjoy an equal housing opportunity. Please use the space below to explain what accommodation(s) the disabled Household Member needs, the length for which it will be needed, and why it is required. If medical equipment is necessary, please include a detailed list of necessary equipment. Attach additional pages if needed.

☐ The Household Member **needs a Live-in Aide**. Please answer the following question.

A daily in-home worker or rotating shifts are not equally effective because:

The Live-in Aide is essential to the medical care and well-being of the person because: Do not disclose nature or extent of the disability, or medical diagnosis

How many hours per day will the Live-In Aide be providing care: ___________________

PART II. CERTIFICATION

Based on your professional opinion and assessment of needs, please check only one of the following:

☐ **I certify** that the enclosed request for changes to the unit or common area or to rules, policies and procedures is necessary for the disabled Household Member, as a result of his/her disability in order to have an equal housing opportunity.

OR

☐ **I cannot certify** that the enclosed request is necessary for the disabled Household Member, as a result of his/her disability in order to have an equal housing opportunity.

Please certify below:

☐ This certification is true and accurate, the best of my professional judgement, and may be used in an administrative hearing or court of law.

Warning: Title 18, Section 1001 of the U.S. Code states that a person is guilty of a felony for knowingly and willingly making false or fraudulent statements to any department of the United States Government. HUD, the PHA and any owner (or any employee of HUD, the PHA or the owner) may be subject to penalties for unauthorized disclosures or improper uses of information collected based on the consent form. Use of the information collected based on this verification form is restricted to the purposes cited above. Any person who knowingly or willfully requests, obtains or discloses any information under false pretenses concerning an applicant or participant may be subject to a misdemeanor and fined not more than $5,000. Any applicant or participant affected by negligent disclosure of information may bring civil action for damages, and seek other relief, as may be appropriate, against the officer or employee of HUD, the PHA or the owner responsible for the unauthorized disclosure or improper use. Penalty provisions for misusing the social security number are contained in the Social Security Act at **208 (a) (6), (7) and (8).** Violations of these provisions are cited as violations of 42 U.S.C. Section **408 (a) (6), (7) and (8).**

______________________________ ______________
Professional's Signature | Date

______________________________ ______________
Name (please print clearly) | Title of Professional or expert

____
Agency or Clinic, if applicable

____
Complete Address

________________ ______________ ______________
Phone | Fax | Email

Please return form to: GMHA

Attention: ______________________________

Address: 538 North Detroit Street
Xenia, Ohio 45385

Phone: ______________________________ Fax: ______________

Email: ______________________________