DISABILITY ACCOMMODATION INFORMATION REQUEST

DATE: _____

TO: _____

HEALTH CARE PROVIDER'S NAME **ADDRESS**

FROM: **Greenbelt Homes, Inc. ("Corporation")**

Resident's Name _____

Address _____

The resident named above ("Resident") has asked the Corporation to provide an accommodation because of his/her disability as follows (description of requested accommodation): _____

_____

Under federal law, if a disabled resident requests a reasonable accommodation because of his/her disability, we must consider the request. To do this, we must verify that the individual qualifies as disabled under federal law and that the requested accommodation is reasonable. You can assist us by answering the questions on this form and returning it to us in the stamped, self-addressed envelope enclosed for this purpose. The Resident's consent to this release of information is set forth below.

DEFINITION OF "DISABLED"
Under federal law, an individual is disabled if he/she has a physical or mental impairment that substantially limits one or more major life activities, has a record of such an impairment, or 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, developmental disabilities, emotional illness, drug addiction, and alcoholism. This definition doesn't include any individual who is a drug addict and is currently using illegal drugs, or an alcoholic who poses a direct threat to property or safety because of alcohol use.

INFORMATION REQUESTED

1. Is the Resident disabled, as defined above? ❑ Yes ❑ No
2. In your professional opinion, is the requested accommodation necessary for the Resident to have the same opportunity that a non-disabled individual would have to use and enjoy the Resident's living quarters?
   ❑ Yes ❑ No
3. If you answered "Yes" to question number 1, can the Resident's condition be otherwise treated to prevent substantial limits on any of his/her major life activities? If so, please describe treatment.

Name & Title of Person Supplying Information _____

Firm/Organization _____

Would you be willing to testify in any court action or other proceeding as to the Resident's need for the requested accommodation?
❑ Yes ❑ No

HEALTH CARE PROVIDER'S SIGNATURE _____

MEDICAL LICENSE # (IF PHYSICIAN) _____

RELEASE

TO THE RESIDENT:

YOU DO NOT HAVE TO SIGN THIS FORM IF THE NAME OR ADDRESS OF EITHER THE CORPORATION OR THE HEALTH CARE PROVIDER IS LEFT BLANK.

RELEASE: I hereby authorize the release of the requested information. Information obtained under this consent is limited to information that is no older than 12 months. There are circumstances that would require the Corporation named above to verify information that is up to five years old, which would be authorized by me on a separate consent, attached to a copy of this consent.

RESIDENT'S SIGNATURE **DATE**