CONFIRMATION OF DISABILITY AND NEED FOR ACCOMMODATION

DATE: _____

TO: _____

MEDICAL PROFESSIONAL'S NAME **ADDRESS**

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

Name of Person with Disability _____

Address _____

The person named above has asked GHI to provide the following ~~a~~ reasonable accommodation because of a disability ~~as follows (description of requested accommodation)~~: _____

Under federal law, if an individual requests a reasonable accommodation because of a 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 requestor's consent to this release of information is set forth below.

DEFINITION OF "DISABLED"
Under federal law, an individual is disabled if they have 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 person identified above~~Resident~~ disabled, as defined above? ❑ Yes ❑ No
2. In your professional opinion, is an~~the requested~~ accommodation/modification necessary for the person~~Resident~~ to have the same opportunity that an individual without a ~~non-~~disability~~led individual~~ would have to use and enjoy their ~~Resident's~~ living quarters or common use areas?

   ❑ Yes ❑ No

Medical Specialty (e.g., orthopedics, cardiology, etc.) _____

Name of Medical Practice _____

MEDICAL PROFFESIONALS SIGNATURE _____

MEDICAL LICENSE # _____

RELEASE

TO THE REQUESTOR:

YOU DO NOT HAVE TO SIGN THIS FORM IF THE NAME OR ADDRESS OF EITHER GHI OR THE LICENSED MEDICAL PROFESSIONAL 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 GHI 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.

REQUESTOR'S SIGNATURE **DATE**