**MIAMI-DADE PUBLIC HOUSING AGENCY**
**REASONABLE ACCOMMODATION VERIFICATION**

Head of Household: ________________ Client No: _______
(PRINT NAME)

Re: Reasonable Accommodation Request

For: ________________________________________ Telephone: ________________
(PRINT NAME OF HOUSEHOLD MEMBER FOR WHOM THE REQUEST IS BEING MADE)

PLEASE RETURN TO: ________________________
(Name of MDPHA Employee)

________________________ ________________________
(Address of MDPHA Employee) (Phone/Fax of Employee)

THE FOLLOWING SECTION IS TO BE FILLED OUT BY THE DESIGNATED VERIFICATION SOURCE:

1. The individual seeking an accommodation is a person with a disability according to the following definition: *"Disability" is defined as a physical or mental impairment that substantially limits one or more major life activities; a record of having such an impairment, or being regarded as having such an impairment*.

   [ ] YES [ ] NO

2. Describe the problem(s) that the person is having with the MDPHA dwelling, building, property, practice, rule, policy, procedure, program or service:

3. Describe the type of change(s), feature(s) or assistance required:

4. **Using the checklist on page 2 of 2, indicate the functional limitation(s) (i.e. the way major life activities are substantially limited) of the person for whom the accommodation is requested.**

5. Please describe the relation between the person's functional limitation(s) and the requested accommodation. Do not provide unnecessary details about the medical history or disabled status of the person seeking an accommodation.

**Name of Verification Source**: ________________________________________
(PRINT NAME OF HEALTH CARE PROVIDER)

**Signature**: ________________________________________ Date: _____/____/_____

**Title of Verification Source**: ________________________________________

**Address**: ________________________________________

**Telephone:** ________________________________**Fax:** ______________________________

 COM/007/REV10-17-08

**FUNCTIONAL LIMITATIONS OF CLIENT'S MAJOR LIFE ACTIVITIES CHECKLIST**

**CLIENT'S NAME:** ________________________________ **CLIENT #:** _______________
Last First

| **TYPE OF MAJOR LIFE ACTIVITIES** *(Check applicable)* | **DISABILITY STATUS** **D**= Disabled* (or) **ND**= Not Disabled *(Enter D or ND as applicable)* |
|---|---|
| ☐ Walking | |
| ☐ Standing | |
| ☐ Climbing | |
| ☐ Bending | |
| ☐ Stooping | |
| ☐ Kneeling | |
| ☐ Use of Hands | |
| ☐ Reaching | |
| ☐ Self Care | |
| ☐ Speaking | |
| ☐ Breathing | |
| ☐ Seeing | |
| ☐ Hearing | |
| ☐ Lifting | |
| ☐ Intelligence (a person's capacity for understanding) | |
| ☐ Thinking (the ability to form or conceive in the mind) | |
| ☐ Perception (the brain's interpretation of internal and external stimuli) | |
| ☐ Judgment (the ability to assess a given situation and act appropriately) | |
| ☐ Mood (emotional tone underlying the behavior) | |
| ☐ Behavior (specifically examining behavior that is disruptive, distressing or aggressive) | |
| ☐ Other (Please Specify in non-technical terms that simply describe what the client cannot do or has difficulty doing) | |
| **HEATH CARE PROVIDER / VERIFICATION SOURCE INFORMATION** | **PRINT NAME:** ____________________________________________<br>**SIGNATURE:** _________________________**DATE**______/_____/____<br>**TELEPHONE NUMBER (______)**________________________________ |
| **NOTES (use additional sheet if necessary):** | |

* "***Disability"*** *is defined as a physical or mental impairment that substantially limits one or more major life activities.*



This material is available in an accessible format upon request. Please call the ADA Coordinator at (786) 469-4229 phone – Florida Relay Service (800) 955-8771 (TDD/TTY).