

Falls Run Community Association, Inc.
Verification for Reasonable Accommodation / Modification

Name of person requiring accommodation/modification:

Description of accommodation/modification being requested:

I understand that under federal and state 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. Major life activities include walking, seeing, hearing, speaking, breathing, thinking, communicating, learning, performing manual tasks, and caring for oneself.

Impairments also include such diseases and conditions as orthopedic; visual; speech and hearing impairments; Cerebral Palsy; autism; seizure disorder; Muscular Dystrophy; Multiple Sclerosis; cancer; heart disease; diabetes; HIV; mental retardation, mental and emotional illness; drug addiction; and alcoholism. This definition does not cover any individual who is a drug addict and currently using an illegal drug, or an alcoholic who poses a direct threat to property or safety because of alcohol use (224 CFR Part 8.3 and HUD Handbook 4350.3, (Exhibit 2-2).

I certify that _____ has a physical/mental (circle) disability which meets the definition stated above.

I verify that this request is directly related to his/her disability and is necessary to afford him/her the opportunity to access housing, maintain housing, or fully use/enjoy housing. (Necessary indicates necessity as opposed to only the matter of convenience or preference).

I recommend that the request for: _____
_____ be approved.

I certify that the information above is true and correct.

Signature: _____ Date: _____

Printed Name: _____

Professional Title: _____

Name of Clinic, Hospital, etc.: _____

Address: _____

Phone Number: _____ Fax Number: _____