Pinellas County Housing Authority
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Fax: 727.489.0773 • TTY: 800.955.8771
www.PinellasHousing.com

DISABILITY VERIFICATION FORM- ADDITIONAL BEDROOM FOR MEDICAL EQUIPMENT

Please complete the form below. If you submit this form with missing or incorrect information, this form will be returned to you to complete, which will delay the processing of your request. This request may require subsequent reviews on an annual basis as part of the recertification process.

Case Manager/Property Manager Name: _____ Date: _____

Health Care provider or other Verification Source (Please Print Legibly)

Name: _____ Phone: _____

Address: _____Fax:_____

VERIFICATION INSTRUCTIONS: The person named below has applied for or is receiving federal assistance through one of our programs. This person has requested an accessible unit, accommodation or modification as described below. We are required to verify that the household member qualifies as "disabled" under federal law, and to determine the disability related need and/or nexus between the requested accommodation and individual disability. I understand that oral verification from health care provider may be required.

HOUSEHOLD MEMBER

Name: _____ Date of Birth: _____

Address: _____

Phone: _____ Email: _____

RELEASE: I hereby authorize the release of the requested information in this form. The information obtained under this consent is limited to information that is no older than 12 months. There are circumstances, which would require the PCHA to verify information that is up to 5 years old, which would be authorized by me on a separate consent and attached to this consent.

SIGNATURE: _____ DATE: _____

HOUSEHOLD MEMBER'S REQUEST

Please provide list of ALL medical equipment that you feel require a separate bedroom. You must have this medical equipment at your home. Requestor shall submit pictures of each item with this request.

_____

_____

INFORMATION REQUESTED (Information below to be filled out by health care provider)

1. Is the household member disabled as defined below? ☐ Yes ☐ No

2. Is the household member's request disability related? ☐ Yes ☐ No

3. Has this medical equipment been prescribed or for recreational use? _____

4. Is this medical equipment a medical necessity? ☐ Yes ☐ No

5. Can you confirm that patient has this medical equipment in their home? ☐ Yes ☐ No

6. Is patient receiving ongoing physical or occupational therapy out of their home? ☐ Yes ☐ No

7. Please explain the NEXUS (a causal link) between the request and the disability.

_____

_____

8. Please describe any other accommodation or modification that could meet the household member's needs in place of what the household member has requested. For example, if there is a less expensive way to help the household member cope with his or her disability, please describe it.

_____

_____

DEFINITION OF DISABILITY

Under Federal Law, an individual is disabled if he or she has a physical or mental impairment that substantially limits one or more major life activity, has a record of said impairment or is regarded as having said impairment. The term physical or mental impairment includes but is not limited to such diseases and conditions as orthopedic visual, speech and hearing impairment, cerebral palsy, autism, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, human immunodeficiency, virus infection, mental retardation, emotional illness, drug addiction and alcoholism. The definition does not include any individual who is a drug addict and who is currently using illegal drugs or an alcoholic who poses a direct threat to property or safety because of alcohol use [24 CFR Part 8.3 and HUD Handbook 4350.3 (Exhibit 2-2)].

Medical Professional Supplying Information:

Name: _____ Title: _____

License Number: _____ Business/Professional Organization: _____

_____ _____

Signature Date

"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.