Chicopee Housing Authority

Medical Verification Form

_____ _____

Head of Household (Print Name) Resident Telephone Number

For: _____ _____

(Print name of household member for whom the request is being made) Resident Telephone Number

Please return it to:

_____ CHA Phone: (413) 592-6132

(CHA employee name)

Chicopee Housing Authority
128 Meetinghouse Rd.
Chicopee, Massachusetts 01013-1830

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 impairment or being regarding as having such impairment.
   _____ Yes _____No

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

   _____

   _____

   _____

   _____

3. Do(es) the person(s) making the reasonable accommodation meet the definition of disability as mentioned in 1. Above?

_____

_____

_____

_____

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

_____

_____

_____

_____

5. Please describe the relationship 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 Title

_____

Company

_____

Signature

_____

Address

_____ _____

Telephone Number Fax Number

CHICOPEE HOUSING AUTHORITY VERIFICATION OF DISABILITY

Name: _____ Date:_____

Address:_____

_____

Dear Resident/Applicant:

You have indicated that you, or a member of your household, need a reasonable accommodation because of a disability in connection with a Chicopee Housing Authority residence, facility, program or service. A physician, licensed health care professional, or a professional representing a social service agency or disability agency or clinic may verify this information.

Please take this letter, the attached *Authorization for Release of Information* and the enclosed pre-addressed envelope to your health care provider or other appropriate individual, clinic or agency. The Chicopee Housing Authority will use this information to evaluate your request for a reasonable accommodation. The Chicopee Housing Authority will keep this information confidential. If you choose not to authorize the release of this information, we may not be able to consider your reasonable accommodation request(s).

MODIFICATION/ACCOMMODATION REQUESTED:

_____

_____

_____

_____

_____

CHICOPEE HOUSING AUTHORITYAUTHORIZATION FOR RELEASE OF INFORMATION REGARDING REASONABLE ACCOMMODATION(S) REQUEST

RE: Household member with disability: _____

I hereby authorize _____

[Insert name of health care provider or other appropriate documenting authority]

to consult with representatives of the Chicopee Housing Authority, in writing, in person, or by telephone concerning the physical or mental impairment(s) that I assert to qualify as a individual with a disability for the sole purpose of this reasonable accommodation request. I hereby authorize the release of information to the Chicopee Housing Authority regarding the request for reasonable accommodation described on this form. This release shall constitute a limited authorization for the release of information, as described below.

This Authorization solely authorizes the release of information necessary to verify the following:

1. **Documentation necessary to verify that the above-named individual meets the definition of a "qualified individual with a disability", as defined below;**

2. **A description of the needed reasonable accommodation(s); and,**

3. **A description of the identifiable relationship between the individual's disability and the requested reasonable accommodation(s).**

For purposes of this Release, a "Qualified Individual With a Disability" is defined as a person who has a physical or mental impairment that:

1. Substantially limits one or more major life activities

2. Has a record of such an impairment

3. Is regarded as having an impairment

"A Physical or Mental Impairment" is defined as:

1. Any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: Neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive; digestive; genito-urinary; hemic and lymphatic; skin; and endocrine; or

2. Any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities. 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, mental retardation, emotional illness, drug addiction and alcoholism. "Major life activities" means functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing and learning.

"Major Life Activities" include functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.

"Has a Record of Such an Impairment (mental or physical)" means has a history of, or has been misclassified as having, a mental or physical impairment that substantially limits one or more major life activities.

"Is Regarded As Having an Impairment" means:

1. Has a physical or mental impairment that does not substantially limit one or more major life activities, **but** is treated by a recipient as constituting such a limitation.

2. Has a physical or mental impairment that substantially limits one or more major life activities **only as**

a result of the attitudes of others toward the impairment.

3. Has none of the impairments defined by Section 504's definition of "physical or mental impairment,
but is treated by a recipient as having such an impairment.

In addition, I authorize _____
[Insert name of health care provider or other appropriate documenting authority]
to provide only documentation that is necessary to verify that I meet the definition of a "Qualified Individual with a Disability", as defined above. This Authorization For Release of Information should only seek information that is necessary to determine if the requested reasonable accommodation is needed because of a disability.

This Authorization does **not** authorize the Chicopee Housing Authority to examine my medical records, including diagnosis or test result(s); nor does this authorize the release of detailed information about the nature or severity of my disability. Any information or documentation released as a result of this Authorization shall be kept confidential and will not be shared with anyone unless required to make or assess a decision to grant or deny a reasonable accommodation request.

_____

Name of Family Member/Parent/Legal Guardian [Print]

_____

Signature

_____

Relationship to Resident

_____

Date

PLEASE PROVIDE THE FOLLOWING INFORMATION:

(1) Name of Health Care Provider/Documenting Authority:

_____

(2) Address of Health Care Provider/Documenting Authority:

_____

_____

(3) Telephone Number of Health Care Provider/Documenting Authority:

_____

(4) Facsimile Number of Health Care Provider/Documenting Authority:

_____