Pierce County Housing Authority

Mailing address: 1525 108th St. So., Tacoma, WA 98444
Physical address: 603 So. Polk St., Tacoma, WA 98444
Ph.: 253-620-5400 Fax: 253-620-5455 TTY: 253-620-5499

Guidance for Health Care and Qualified Professionals: Verifying Reasonable Accommodation and Modification Requests

Dear Health Care Provider or Qualified Individual:

Fair housing laws allow an individual who has a physical, mental or sensory disability to request that a housing provider grant him/her a reasonable accommodation or modification (a change in rules, policies, or practices; or a facility modification). Once a person has made a request, a housing provider may request verification from a qualified expert (a doctor, medical professional, or other qualified third party who, in their professional capacity, has knowledge about the person's disability). The verification should state that the person is disabled, that the request is necessary, and related to the disability.

For the purposes of requesting a reasonable accommodation/modification in housing in Washington state, disability is defined as **"the presence of a sensory, mental, or physical impairment that: (i) is medically cognizable or diagnosable or (ii) exists as a record or history or (iii) is perceived to exist whether or not it exists in fact."** Additionally, "a disability exists whether it is temporary or permanent, common or uncommon, mitigated or unmitigated … or whether or not it limits any other activity…."

The verification should include the following items:

I. **Qualification of person** writing the verification letter.

II. **Nature of contact** the professional has had with the person making the request.

III. **Statement that** the client has an impairment that meets the state definition of disability.

> **Important Note:** Revealing a diagnosis puts your client at risk of additional discrimination. Before naming a specific diagnosis, you need your client's informed consent. If a client wants the diagnosis kept confidential, it is advisable to use a general description such as "mental condition" without naming the specific diagnosis.

IV. **Effects of Impairment.** Please describe how the impairment affects one or more major life activities. "Impairments" include physiological, mental, psychological or physical diseases, disorders or conditions. Examples of major life activities are self-care, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and communication.

V. **Describe how the accommodation/modification requested is necessary** to afford the person the opportunity to access housing, maintain housing, or for full use and enjoyment of the housing. Be sure to use words like: "necessary," "essential," "prescribed"; when describing why the condition creates a need for the accommodation or modification, because housing providers must make only those accommodations or modifications that are necessary. The role of the verifier is to establish that the need derives from the disability.

Please have Care Provider return completed form to:
Pierce County Housing Authority
1525-108th Street South, Tacoma, WA 98444
Fax: 253-620-5455
Phone: 253-620-5400

Verification for Reasonable Accommodation / Modification

Client Name:_____

Accommodation Requested:_____

_____

_____

I. I certify that I am a: ☐Licensed medical doctor
☐Medical professional
☐Other (please specify)_____

II. ☐ I certify that the above named client is a person with a disability as defined by the Washington Law Against Discrimination (RCW 49.60).

III. ☐ I have treated the above named client since ___/___/_

IV. ☐ The most recent evaluation and/or treatment was conducted __/__/____

V. Please describe how the impairment affects one or more major life activities:

_____

_____

VI. Please describe how the accommodation is necessary to afford the person the opportunity to access housing, maintain housing, or for full use and enjoyment of the housing:

_____

_____

VII. Please describe how the reasonable accommodation you are requesting is connected to and will impact the client's disability:

_____

_____

Signature: _____

Printed Name: _____

Name of Clinic, Hospital, Organization: _____

Address: _____

Phone: _____Fax: _____

Email: _____

Date: _____/_____/_____