Bloomington Housing Authority
Request for Live-In Aide and/or Extra Bedroom

Dear Health Care Professional,

Your Client is a household member of a family that has applied for or is receiving federally subsidized housing assistance. This person has requested a live-in aide and/or an extra bedroom as a disability accommodation.

A disabled, elderly, or nearly elderly (50 to 61 years of age) person may be eligible to add a person to the unit or add an additional bedroom as a reasonable accommodation if it is shown that the accommodation is necessary to afford the person an equal opportunity to use and enjoy his/her residential unit.

We ask that you carefully review this patient's request and verify that in your professional opinion, the information supplied on the applicant's "Request for Reasonable Accommodation" form is truthful and justifies a reasonable accommodation (see attached form).

If your client's request is granted, the housing agency will allow the family an extra bedroom and not count the live-in aide's income in calculating the rent. This affects the total number of families the housing agency can assist. Many other people on the waiting list are also deserving of housing assistance, so we ask that you give careful, reasoned thought to this matter.

If you have any questions while completing this form please contact: _____ at telephone number (812) 339-3491 Ext:_____

Thank you,
BH

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Head of Household: _____

Household Member who requires the accommodation(s): _____

Address: _____ Apt #: _____

Primary phone # :( ) _____ Secondary Phone #: ( ) _____

THIS FORM MUST BE COMPLETED BY A QUALIFIED MEDICAL, REHABILITATION, OR NON-MEDICAL SERVICE AGENCY PROFESSIONAL WHOSE FUNCTION IS TO PROVIDE SERVICES TO PEOPLE WITH A DISABILITY AND MAY VERIFY YOUR HOUSEHOLD MEMBER'S NEED FOR A REASONABLE ACCOMMODATION.

Please answer all applicable questions on this form

The above Household Member is applying for a reasonable accommodation at the Bloomington Housing Authority (BHA) and is requesting that you, as his/her provider fill out the following certification. Enclosed is a copy of the BHA's Request for Reasonable Accommodation with a signed authorization for release of information.

Please mark all that apply

1. In my professional assessment:

   □The Household Member is a person with a disability based on the following legal definitions (please mark all that apply):

   □He/she has a physical or mental impairment that significantly limits one or more major life activities

   □He/she has a record of or is regarded as having such impairment

   □The Household Member requesting the accommodation(s) is not a person with a disability (If applicable proceed to page 5 and sign and return the form listed on the header)

2. Please indicate familiarity with applicant

   □I have met with this individual to discuss his/her disability within last six months

   □The last time I met with this individual to discuss his/her disability was over six months ago

   □Other (please explain): _____

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Changes to the rules/policies/procedure due to disability

NOTE: *Please fill out this section **ONLY** if the Household Member with a disability needs a change to the rules, policies, or procedures due to his/her disability. Otherwise this portion is N/A.*

□The Household Member needs a change in a policy or procedure as a direct result of his/her disability in order to enjoy an equal housing opportunity. Please use the space below to explain what accommodation(s) the Household Member with a disability needs, the length for which he/she will need it and why it is required.

NOTE: *The applicant requires Personal Care Attendant (PCA) if the applicant needs a 24-hour or overnight live-in PCA. If true please explain in detail the following:*

a. If your agency will provide the PCA
b. If a family member is identified as the PCA, provide the individual's complete name, relationship to the Household Member with a disability, and if that individual is qualified to perform the required duties per your professional opinion and assessment.

NOTE: ***Please fill out this section ONLY if the Household Member needs a unit and/or common area with specific features due to his/her disability. Otherwise this portion is N/A.***

Disclaimer: The following information requested is solely for the purpose of identifying the unit (size, type, and design) that most appropriately meets the needs of the Household Member with a disability. The BHA will make every effort to make the appropriate modifications or identify an appropriate unit based on your professional opinion and assessment. Please note certain requested features may inhibit an exact accommodation.

In my professional opinion and assessment of the Household Member's needs, I certify that:

1. □The Household Member with a disability does **NOT** need a wheel chair-accessible unit but needs a unit or common area with certain physical features. This may include assistive technology. In the space below please describe any additional information you believe may be pertinent.

2. □The Household Member with a disability needs a wheelchair-accessible unit with the following features:

3. □The Household Member with a disability requires a unit in a specific or alternative location due to a disability but does not need any physical changes to a unit or common area and does not need a wheelchair-accessible unit.

Please use the space below to explain and provide details as to why the accommodation(s) is necessary as a result of his/her disability in order to enjoy an equal housing opportunity

a. Describe any other feature(s) not captured on pages 3 and 4, including special housing features, type(s) of physical adaptations and/or assistive technology that is necessary
b. Explain in detail why the required feature(s)/accommodation(s) is **necessary** due to the disability
c. Explain **for how long** the feature(s) accommodation(s) will be needed
d. If the Household Member is currently a BHA resident, and a transfer is necessary, explain in detail **why**. Are there any other alternatives to a transfer that the BHA may provide?

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Certification

1. Based on your professional opinion and assessment of needs please **check only one** of the following:

   □**I certify** that the enclosed request for change(s) to the unit, common area, or to the rules, policies, and procedures are necessary for the Household Member, as a result of his/her disability in order to have an equal housing opportunity.

   □**I cannot certify** that the enclosed request for change(s) to the unit, common area, or to the rules, policies, and procedure is necessary for the Household Member as a result of his/her disability in order to have equal housing opportunity.

   □**I do not believe** the Household Member needs a change to the unit, common area, or to the rules, policies, and procedures as a result of his/her disability in order to have an equal housing opportunity.

   □**I certify** that the identified Household Member is **not disabled**, therefore does not need a change to the unit, common area, or to the rules, policies, and procedures as a result of a disability in order to have an equal housing opportunity.

Medical Provider's signature Date

Name (please print) Title of Medical or rehabilitation professional or expert

Agency of Clinic if applicable

Complete Address

Phone Fax

Please return or fax this completed form to:
Fax #: (812) 339-7177

BHA caseworker
1007 N Summit St.
Bloomington, IN 47404