LETTERHEAD OF HEALTH CARE PROVIDER

Date_____

Dear Fair Housing Manager, Newton Housing Authority:

At the request of (Client's Name) I am submitting this letter as the documentation for their reasonable modification request to you. I fully understand that this request is made under the Fair Housing Amendments Act of 1988 (FHAA). I also understand that under the FHAA Sec. 804, I as the health care provider, must only identify that they have a disability but not the nature or severity of such disability, and I must only indicate that because of this disability, the requested reasonable modification is necessary to provide an equal housing opportunity.

I therefore disclose with the full authorization of (Client's Name) the following:

1. In my opinion the Applicant or Tenant has a disability as defined below.

[ ] YES Proceed to Question 2.

[ ] NO Proceed to signature section.

(A) A physical or mental impairment that substantially limits one or more major life activity; or
(B) A record of having such an impairment; or
(C) Is regarded as having such an impairment

2. In my professional opinion the person listed above

[ ] Requires the changes to the unit or common area described on the enclosed request in order to have equal access to his or her apartment or the development's facilities as a result of his or her disability. Attached hereto find the said request which I have reviewed and initialed; or

[ ] Requires the following changes to the apartment or common areas in order to have equal access to his or her apartment or the developments facilities as a result of his or her disability. Please indicate, if known, where any specialized equipment may be obtained.

_____
_____
_____
_____; or

[ ] Does not require the requested change or any other change in order to have equal access to his or her apartment or the development's facilities as a result of his or her disability; or

[ ] I am not able to verify that the enclosed request for changes to the unit or common area is necessary in order to have equal access to the apartment or the development's facilities as a result of the above named person's disability.

Signature_____ Date_____
Title_____ Organization_____
Address_____

CLIENT/PATIENT AUTHORIZATION

I hereby authorize the release of this requested information to verify my eligibility and need for the reasonable modification I seek. I understand that this information will be kept confidential and will be used only for the purposes stated. This authorization shall expire 60 days after the date signed.

Signed_____ Date_____