WASHINGTON COUNTY HOUSING AUTHORITY

100 S. Franklin Street
Washington, Pennsylvania 15301
TDD Number: 724-228-6083
Office Number: 724-228-6060
Main Fax Number: 724-228-6089
Accounting Dept. Fax Number: 724-228-8685
Purchasing Dept. Fax Number: 724-228-6154
www.wchapa.org • Email: wcha@wchapa.org

CERTIFICATION OF NEED FOR REASONABLE ACCOMMODATION AND THIRD-PARTY VERIFICATION

Housing Choice Voucher Program

IMPORTANT: This form is to be completed by a qualified medical, rehabilitation, or other non-medical service agency professional who is competent to render an opinion because the professional is knowledgeable about the individual's situation and disability-related need. This verification section may not be completed by the applicant, resident, participant, or household member.

A. APPLICANT / RESIDENT / PARTICIPANT INFORMATION

Date

Name of Party Requesting the Reasonable Accommodation

Telephone Number

Last Four Digits of SSN

Address

City

State

ZIP Code

RETURN COMPLETED FORM TO

Washington County Housing Authority 100 S. Franklin Street Washington, Pennsylvania 15301 Attn: HCVP

Email: markh@wchapa.org
Phone: 724-228-6060 ext. 104

LIMITED VERIFICATION NOTICE

WCHA is not requesting a diagnosis, treatment information, medical records, or details concerning the nature or extent of the disability.

WCHA requests only information necessary to determine whether the individual meets the applicable disability definition and whether there is a disability-related need for the requested accommodation.

For this verification, disability generally means a physical or mental impairment that substantially limits one or more major life activities, or a record of such an impairment, as applicable under federal fair housing and disability requirements.

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DIRECTORS
Steven M. Toprani, Chairman
Monique Taylor
Dipesh Patel
Clyde Wilhelm

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DENNIS C. FISHER
Interim Deputy Executive Director

GARY J. MATTA
Solicitor

THIRD-PARTY VERIFICATION OF DISABILITY-RELATED NEED

To Be Completed by the Knowledgeable Professional / Reliable Third Party

B. DISABILITY STATUS

1. Name of Applicant / Resident / Participant / Household Member

2. Based on your professional, service-provider, or other reliable knowledge, does the individual meet the applicable definition of a person with a disability?

☐ Yes ☐ No ☐ Unable to determine

If Yes, check each applicable basis:

☐ Physical or mental impairment that substantially limits one or more major life activities.

☐ Record of having such an impairment.

C. DISABILITY-RELATED NEED / NEXUS

3. In your opinion, is the requested reasonable accommodation necessary to provide the individual an equal opportunity to use and enjoy housing or participate in the housing program because of a disability-related need?

☐ Yes — I certify there is a disability-related need for the requested accommodation.

☐ No — I do not certify a disability-related need for the requested accommodation.

☐ Unable to determine based on my knowledge of the individual.

Requested Reasonable Accommodation, as Understood by the Verifier

4. Without stating a diagnosis or describing treatment, explain the relationship (nexus) between the individual's disability-related functional limitation or need and the requested accommodation.

Disability-Related Need / Nexus

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THIRD-PARTY VERIFICATION OF DISABILITY-RELATED NEED — CONTINUED

D. FUNCTIONAL LIMITATION / SERVICES NEEDED

5. Describe only the functional limitation or disability-related need relevant to the accommodation request. Do not provide a diagnosis, treatment history, medications, or unrelated medical information.

Relevant Functional Limitation / Disability-Related Need

If relevant to the request, provide limited functional information such as the type and duration of assistance needed for self-care, an approximate walking or standing limitation, or a lifting limitation. Provide only information necessary to evaluate the accommodation.

Limited Functional Details Relevant to the Request

E. EFFECTIVE ALTERNATIVES

6. Are there other accommodations or modifications that could effectively meet the individual's disability-related need instead of the accommodation requested?

☐ Yes ☐ No ☐ Unable to determine

If Yes, Describe the Effective Alternative(s)

F. BASIS OF KNOWLEDGE

7. How long have you known, treated, or provided services to the individual? Do not include treatment details.

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THIRD-PARTY VERIFICATION — VERIFIER QUALIFICATIONS AND CERTIFICATION

G. VERIFIER QUALIFICATIONS

8. State your qualifications, professional credentials, or service relationship that make you competent to provide this verification. If you are a physician or state-licensed professional, provide your Pennsylvania license number when applicable.

Qualifications / Professional Credentials / Basis of Knowledge

Pennsylvania Professional / Medical License Number, if applicable

H. VERIFIER CERTIFICATION

I certify that the information provided on this form is based on my professional, service-provider, or other reliable knowledge of the individual and is true and accurate to the best of my knowledge. I understand WCHA staff may contact me to verify or clarify the limited information provided concerning the disability-related need for the requested accommodation.

I understand that information I provide may be subject to applicable administrative or legal processes. This certification does not require me to disclose a diagnosis, complete medical record, treatment history, or information unrelated to the accommodation request.

If You Are Unable to Provide Testimony or Further Verification, State the Reason, if applicable

Verifier — Type Full Name as Signature

Date

Print Name

Telephone Number

Professional Title

Fax Number / Email

Organization / Agency

WCHA CONFIDENTIALITY NOTICE

Disability-related information and reasonable accommodation records are confidential and should be used or disclosed only as necessary to evaluate, implement, document, and administer the accommodation request and applicable housing program requirements.