

Verification of Status as a Person with a Disability

Housing Provider: Name: MDOC

Address: PO Box 200545

City/State/Zip: Helena, MT 59620

Name of Tenant/Applicant/Guest Requesting a Reasonable Accommodation or Modification:

The tenant, guest, or applicant listed above needs the reasonable accommodation or modification described in the attached Request for a Reasonable Accommodation or Modification form. State and federal laws require housing providers to make reasonable modifications and/or accommodations to either the dwelling or other parts of the housing community and/or to policies, procedures, services or regulations when such changes are not unduly burdensome and are necessary because of a disability of an applicant, a household member, or a guest, so that the applicant, household member or guest can have an equal opportunity to use and enjoy the housing and/or facilities.

The Fair Housing Amendments Act, Section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act, and the Montana Human Rights Act define "disability" as:

- a physical or mental impairment that substantially limits one or more major life activities;
- a record of having such an impairment;
- being regarded as having such an impairment.

A physical or mental impairment includes, but is not limited to:

- any physiological disorder or condition;
- cosmetic disfigurement;
- anatomical loss affecting one or more of the following body systems: neurological, musculoskeletal, special sense organs, respiratory, speech organs, cardiovascular, reproductive, digestive, genito-urinary, hemic and lymphatic, skin, and endocrine.
- Any mental or psychological disorder, such as cognitive delays, organic brain syndrome, emotional or mental illness, and/or learning disabilities.
- Drug addiction and alcoholism are covered by these provisions as are, for example, cancer, heart disease, HIV, AIDS, and some temporary disabilities (such as broken limbs or symptoms arising from pregnancy).

The term "**major life activity**" means those functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working ([24 C.F.R. § 100.201\(b\)](#)). The factors considered when determining if a person is substantially limited in a major life activity are the nature and severity of the impairment, the duration or expected duration of the impairment, and the expected permanent or long term impact of the impairment ([29 C.F.R. § 1630.2\(j\)\(2\)](#)).

IMPORTANT: The health care provider certifying the disability and need for an accommodation and/or modification **IS NOT** required to reveal the specific nature and/or severity of the individual's disability, **NOR** specific information about treatment.

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As a health care provider with the knowledge necessary to make a determination, I am able to advise that

(name of client)

qualifies as an individual with a disability as defined above and that the following accommodation or modification is consistent with the needs associated with his/her disability.

Accommodation/Modification Requested:

Expected duration of disability:

Lifetime

Specify Length if Not Lifetime: _____

Please describe the major life activities limited by the disability that specifically relate to the need for the request for a reasonable accommodation or modification:

Please describe how this request for a reasonable accommodation or modification will specifically help ameliorate the limitations of the major life activities referenced above:

Signature of Health Care Provider

Printed Name and Title

Phone Number: _____

Date: _____
