



CARE PROVIDER CERTIFICATION

EXTRA ROOM / REASONABLE ACCOMMODATION

The person requesting an extra bedroom, _____, has asked that you complete this certification regarding their request: A release form authorizing you to provide this information is attached.

- 1. What is your relationship to this person, and what qualifies you to make the assessments sought on this form?
2. This person is (check any that apply): [] elderly 62+ [] near elderly 50-61 [] disabled* [] N/A
3. What is the anticipated duration of the disability/circumstance for which the accommodation was requested?
4. Is an extra bedroom necessary to allow the person equal access to use and enjoy their housing program/unit?
5. Is the need for the bedroom due specifically to their elderly status, disability, or medical condition?
6. How will the extra bedroom be used?
7. Why are other spaces (such as the living room) inadequate?
8. How will an extra bedroom remove barriers and limitations posed by the person's disability?
9. Would you be willing to testify on the patient's behalf to the information provided on this form?

I certify that it is my professional opinion that the above-named person has a qualified disability that has a verifiable need for accommodation. I certify my professional opinion is in compliance with applicable laws, regulations, standard industry practices and licensing guidelines.

Signature Name Date
Address Title Phone

WARNING: Title 18, Section 1001 of U.S. Code states that a person is guilty of a felony for knowingly and willingly making a false or fraudulent statement to any department or agency of the United States Government.