



Dear Health Care Provider:

The individual listed below considers him or herself to be disabled and has asked for an accommodation from this agency to meet certain needs he or she believes are dictated by the disability. The Housing Authority of the County of San Bernardino (HACSB) grants reasonable accommodation requests based in part by verification of need from a health care provider who has direct experience with an individual's disability. You have been authorized to release information to us regarding the need for an accommodation.

PART I. RESIDENT INFORMATION

Last Name		First Name		Middle Initial
Address				
City	State	Zip Code	Daytime Telephone Number ()	

I, _____ authorize _____
(Applicant/Resident/Participant's Name) Health Care Provider

to disclose relevant information to HACSB regarding the need for a reasonable accommodation. I understand the information that HACSB obtains will be kept confidential and used solely to determine if an accommodation should be provided. I declare under penalty of perjury under the laws of the State of California that the foregoing information is true and correct. (California Penal Code Section 118.)

Signature of Applicant/Resident/Program Participant

Date

Please return completed, signed and dated forms to: HACSB

Attention:
ADA Coordinator
Housing Programs Office
672 S. Waterman Ave.
San Bernardino, CA 92408

PART II. THIS SECTION TO BE COMPLETED BY A LICENSED OR CERTIFIED HEALTH CARE PROVIDER

A “disability” is defined as a physical or mental impairment which limits one or more of a person’s major life activities¹, a record of having such an impairment, or being regarded as having such impairment.

1. Does this individual have a disability, as defined above? Yes ___ No ___
2. If yes, does this individual, because of this disability, need a reasonable accommodation made to either their unit, or other parts of the housing complex, or to house rules, policies, practices, or services of the HACSB to have an equal opportunity to use and enjoy his or her dwelling? Yes ___ No ___
3. If yes, please describe the accommodation needed (which must directly relate to the accommodation requested. Changes must be necessary, NOT only desirable):

Use separate sheet to provide additional information (please print clearly)

¹ Major life activities include, but not limited to: performing tasks, caring for oneself, walking, talking, seeing, hearing, breathing, learning, or working.

PART III. HEALTH CARE PROVIDER INFORMATION

I declare under penalty of perjury under the laws of the State of California that the foregoing information is true and correct. (California Penal Code Section 118.)

Agency Stamp

PENALTIES FOR MISUSING THIS CONSENT:

Title 18, Section 1001 of the U.S. Code states that a person is guilty of a felony for knowingly and willingly making false or fraudulent statements to any department or Agency of the United States Government. HUD and any PHA (or any employee of HUD or the PHA) may be subject to penalties for unauthorized disclosures or improper uses of information collected based on the consent form. Use of the information collected based on this verification form is restricted to the purposes cited above. Any person who knowingly or willingly requests, obtains, or discloses any information under false pretenses concerning an applicant or participant may be subject to a misdemeanor and fined not more than \$5,000. Any applicant or participant affected by negligent disclosure of information may bring civil action for damages and seek other relief, as may be appropriate, against the officer or employee of HUD or the PHA responsible for the unauthorized disclosure or improper use. Penalty provisions for misusing the social security numbers are contained in the Social Security Act at 208 (a) (6), (7) and (8). Violations of these provisions are cited as violations of 42 USC 408 (a) (6), (7) and (8).

Health Care Provider's Signature		Date of Exam	
X			
Health Care Provider's Name (Print)		License or Certificate Number/Issuing State	
Title:			
Address			
City	State	Zip Code	Telephone Number ()