City of Boulder
Planning, Housing and Sustainability

Homeownership Program
DISABILITY ACCOMMODATION VERIFICATION

1. APPLICANT CONSENT SECTION

Please complete the top part of this form and return it to the City of Boulder. Do not take this form to your physician or health care provider. The City of Boulder will submit the form to your provider. You are encouraged to submit the form to the city as soon as you are able in order to give sufficient time for your health care provider to process the form.

Information about your physician or care provider:

Physician/care provider name _____

Street address _____

City, State, Zip Code _____

Phone Number _____

E-mail address _____

The U.S. Department of Housing and Urban Development (HUD) and other entities/programs permit program administrators to verify that you or a member of your household have a disability if:

1. Your eligibility for program criteria is dependent on you being a person with a disability; or
2. You or a member of your household require accommodations related to the application process due to a disability in order to have equitable access to, and enjoyment of, the program; or
3. You or a member of your household require the unique features that a particular unit may provide due to a disability, in order to have equitable access to, and enjoyment of, the home. Features must be necessary as a result of the disability.

I give permission to the City of Boulder Homeownership Program to contact the physician/care provider listed above to verify the need for an accommodation related to the application process or preference for homes with unique features for myself or a member of my household. I give permission for this information to be released to the City of Boulder Homeownership Program.

Patient's Printed Name _____

Patient's Date of Birth _____

_____ _____
Patient's Signature or the signature of a legal guardian Date Signed

Note to Applicant: Do not sign this form unless you have completed the information above or agree with the information that has been completed above.

2. PHYSICIAN/CARE PROVIDER SECTION
The above Applicant is seeking to obtain housing through the City of Boulder Homeownership Programs.

Provisions of the programs require verification of Applicant provided information.

The Applicant signed the consent section above giving you permission to supply us with the information requested. The information you provide will remain confidential and only be used for the purpose of determining accommodation related to the application process or preference for homes with unique features.

Please provide the information requested below and promptly return this form to the following:
homeownership@bouldercolorado.gov
or
City of Boulder Homeownership Program
PO Box 791
Boulder CO 80306
or
Fax – 303-441-4149

1. I certify that this verification was sent directly to the organization supplying the information and was not hand-carried by the patient/applicant or any other interested party.
   ☐ yes ☐ no

2. To my knowledge the above listed patient is disabled per one or more of the HUD definitions as follows:
   A. A person having a physical, mental, or emotional impairment that is expected to be of long-continued duration.

   B. A person with a developmental disability as defined in Section 102(7) of the Developmental Disabilities Assistance and Bill of Rights Act (42 U.IS.C.6001(8).

   C. A person with a chronic mental illness that seriously limits his or her ability to live independently, and whose impairment could be improved by more suitable housing conditions.

   NOTE: Any person receiving disability solely due to a drug or alcohol problem would not be considered disabled under housing law

   The person named above meets one or more of the criteria listed in A, B, or C?
   ☐ yes ☐ no

3. If this patient has a disability, do they have an impairment that results in the need for accommodation related to the application process?
   ☐ yes ☐ no

   Please describe the accommodation needed in the application process which is needed as a result of the disability.

   _____

   _____

4. If this patient has a disability, do they have an impairment that results in the need for special design features in a home?
   ☐ yes ☐ no

   Please describe the features they need in a home as a result of the disability (not the disability). For example, they need a home without steps – (not they are in a wheelchair).

   _____

   _____

   _____

5. If necessary, would you be willing to testify under oath, in a court of law to the information being provided in this form?
   ☐ yes ☐ no

PENALTIES FOR MISUSING THIS FORM:
Co Rev Stat § 18-5-102 states that a person is guilty of a class 5 felony, if, with intent to defraud, such person falsely makes, completes, alters or utters a written instrument which is or purports to be a written instrument officially issued or created by a public office, public servant, or government agency.

Name and Title of the Person Supplying Information: _____

Phone Number: _____

E-mail address _____

_____ _____
Signature Date Signed