OAKLAND HOUSING AUTHORITY
1540 Webster St. Oakland, CA 94612
(510) 587- 2100
http://www.oakha.org

KAISER PERMANENTE

QUALIFIED INDIVIDUAL'S CERTIFICATION OF NEED FOR REASONABLE ACCOMMODATION

INSTRUCTIONS FOR PARTICIPANT OR APPLICANT

Date:

Re: _____
(write the name of the family member who is a person with a disability and needs a Reasonable Accommodation)

Bring all pages of:

- this cover letter
- the attached two page certification form
- the two page Request for Reasonable Accommodation form that you filled out

to the Medical Secretaries Department at the Kaiser facility where the person named above receives care.

Dear doctor, health care provider, or other qualified individual:

The person named above reported being under your care, and authorized you to release information to us about whether they meet the definition of a person with a disability, and whether the limitations imposed by the disability require the Requested Accommodation.

We have attached two documents for you to review:

1) The *Request for Reasonable Accommodation* form was completed by the patient.
   - the accommodation they are asking for is located on page 1.
   - the authorization to release information is located towards the bottom of page 2.

2) The blank *Certification* form is for you to complete.

   Please complete both pages of the attached *Certification* form legibly.

   Feel free to attach additional pages if you need more space for your answers.

Once completed, let your patient know to pick up all of the enclosed documents from you, and return them to us at 1540 Webster St Oakland, CA 94612.

If we do not receive your response **within 15 business days of the date of this letter,** the request **will be denied.**

If you have any questions about completing this form, please contact OHA at (510) 587-2100.

Thank you for responding promptly.

Sincerely,

Leased Housing Department
Oakland Housing Authority

Part I – Certification of Disability

Disabled, with respect to a person--

(1) a physical or mental impairment which substantially limits one or more of such person's major life activities,

(2) a record of having such an impairment, or

(3) being regarded as having such an impairment, but such term does not include current, illegal use of or addiction to a controlled substance (as defined in section 102 of the Controlled Substances Act (21 U.S.C.802)).

In my professional assessment, _____:
(write the name of the person you are assessing)

☐ Is disabled as defined above

☐ Is **not** disabled according to any of the above definitions

Part II – Accommodation of Disability *{only complete parts II & III if the person is disabled}*

In my professional assessment, the disability I certified above:

*(choose **only one** of the following)*

☐ does **not** impose limitations that require the requested accommodation.

☐ I cannot certify whether they require the Requested Accommodation because:

_____

_____

☐ does impose limitations that require the requested accommodation.

1) Describe the major life activities that are substantially limited by the disability.

_____

_____

_____

_____

_____

_____

2) When should the accommodation be renewed? In _____ or _____.
Months Years

PART III – Live-in Care *{only complete part III if the requested accommodation was for a Live-in Aide}*

Given the request for a Live-in Aide, in my professional assessment:

*(*choose **only one for each** of the following questions*)*

1) Does the person's disability require a care provider to live with them?

☐ No ☐ Yes If Yes, please explain why a daily in-home worker is not equally effective as a reasonable alternative to a live-in aide:

_____

_____

_____

_____

2) How often is live-in care required? ☐ Occasionally/Intermittently ☐ Around the clock care, every day.

3) The disabled person requires live-in care: ☐ Permanently ☐ Short-Term for: _____ or _____.
Months Years

4) For what major life activities does the disabled person require the assistance of a live-in aide?

_____

_____

_____

_____

PART IV – Certification

I certify under penalty of perjury that the statements and representations I have made are true and correct, based on my professional knowledge of the individual assessed above, _____.
(write the name of the person you are assessing)

Physician/Health Care/Service Provider's Signature	Date
Physician/Health Care/Service Provider's Printed Name	Title
Email	License Number, if applicable
Address	City, State, Zip Code
Phone Number	Fax Number

WARNING: Any person who signs this statement and who willingly states as true, any matter which they know to be false, is subject to the penalties prescribed for Perjury in Section 118 of the California Penal Code and Section 11054 of the Welfare and Institutions Code.