Certification of Eligibility for Disability Set Aside Unit

(To be Completed by the Applicant)

Applicant/Head of Household Name: _____

Phone Number: _____

Current Address:

Building (House) #	Street	Apartment #

City	State	Zip

This form is to be submitted to housing developers by affordable housing applicants who have been selected for eligibility review and who have indicated on the application the need for a unit that is accessible or adaptable for a mobility-disabled household member or a household member with a vision or hearing disability.

The applicant must complete the first page of this form and have the second page completed by an appropriately licensed medical professional and bring both pages to the interview.

Name of Household Member Who Has a Mobility, Vision or Hearing Disability: _____

Relationship to Applicant: _____

1. Does the named household member use a wheelchair or does s/he/they otherwise have a mobility disability? ☐ Yes ☐ No
2. If yes, is the mobility disability expected to continue for at least 12 months or longer? ☐ Yes ☐ No
3. Does s/he/they have a hearing disability? ☐ Yes ☐ No
4. Does s/he/they have a vision disability? ☐ Yes ☐ No

I certify that the above statements are true to the best of my knowledge. I understand that supplying false information can lead to the denial of my housing application. I authorize the developer and the Department of Housing Preservation and Development of the City of New York (HPD)/NYC Housing Development Corporation (HDC) to verify my eligibility with my appropriate licensed health care professional and I authorize my health care professional to provide such verification to the developer and HPD/HDC, on their request.

Signature of Household Member Who Has a Mobility, Vision, or Hearing Disability (or Legal Guardian): _____

Date: _____

Verification of Mobility, Vision, or Hearing Disability

(To be Completed by a Licensed Medical Professional)

Applicant/Head of Household Name: _____

Name of Household Member Who Has a Mobility, Vision or Hearing Disability: _____ **DOB:** _____

Relationship to Applicant/Head of Household: _____

The Applicant/Head of Household is seeking to be deemed eligible for a dwelling unit that is accessible or can be adapted for use by an individual who has a mobility, vision or hearing disability (as described below) A federal law, Section 504 of the Rehabilitation Act, requires that a certain percentage of dwelling units in this development be set aside for people with mobility, visual and hearing disabilities who need accessible/adaptable units. An appropriate licensed medical practitioner must confirm that a household member has one or more of the following disabilities: mobility, visual and hearing, in order for the household to be considered for an accessible/adaptable unit.

In your professional opinion:

1. Does the named household member have a mobility disability to such a degree s/he/they would benefit from a unit designed for people with a mobility disability? Such units are designed to meet Universal Federal Accessibility Standards, which can be found at: hudexchange.info/resources/documents/ufas-accessibility-checklist.pdf ☐ Yes ☐ No
2. If yes, is the mobility disability expected to continue for at least 12 months or be of indefinite duration? ☐ Yes ☐ No
3. Does the named household member have a hearing disability to such a degree s/he/they would benefit from a unit for people with a hearing disability (a unit that is wired to support such features as a strobe light smoke alarm and doorbell and other assistive technology)? ☐ Yes ☐ No
4. Does the named household member have a vision disability to such a degree s/he/they would benefit from a unit for people with a vision disability (a unit that is wired to support such features as appropriate audio alarms and other assistive technology)? ☐ Yes ☐ No

I swear/affirm under penalty of perjury that the information above is accurate and true.

Name: _____ Title: _____

Signature: _____ Date: _____

Address: _____ Telephone Number: _____

License Number: _____

Stamp:

This form is valid for one year after the date of the medical professional's verification.