The Lucas Organization LLC.
71 Commercial Street
P.O. Box 292
Boston, MA 02109
Phone: (617) 777-2505

October 23, 2023

via United States Postal Service

Person
123 Main Street
Apt. 1
Boston, MA 02109

RE: Requested Accommodation or Modification

Dear Applicant/Tenant,

You have requested accommodation or modification for renting the property at _____, based on your needs as a person with a disability. As a housing provider, I am legally obligated—and more than happy—to follow the law.

In order to advance your application, please provide me with documentation of your disability by _____. If you feel that you need more time than this to obtain the documentation, please let me know as soon as possible. For information on the kind of documentation that is acceptable, please refer to the U.S. Department of Housing and Urban Development's Guidance on Documenting an Individual's Need for Assistance Animals in Housing.

For your convenience, I am providing you with the following form, Verification of Disabled Status By a Health Care Professional. Please note that *I do not require* that you and your health care professional use this form. You may supply the needed information in another written format if you like. If you are requesting an accommodation to keep an animal other than a dog, cat, small bird, rabbit, hamster, gerbil, other rodent, fish, turtle, or other small, domesticated animal that is traditionally kept in the home for pleasure rather than for commercial purposes, please also have your health care provider specify: the date of your last consultation, any unique circumstances justifying your need for the particular animal(s), and whether the provider has reliable information about this specific animal or whether the provider specifically recommended this type of animal.

If you have any questions or concerns, please contact me as soon as possible.

Sincerely,

_____
Landlord/Manager
cc.
Encs.

Verification by Physician or Other Qualified Professional of Disability Requiring Reasonable Accommodation/Modification to Housing Policies

MESSAGE TO PHYSICIAN OR OTHER QUALIFIED PROFESSIONAL

The landlord below is requesting verification that an applicant or resident has a disability. This information will be used to determine whether the applicant/resident needs an accommodation in the landlord's rules, policies, practices or services, or needs a modification of the leased premises or public or common use areas. **Documentation may be provided in any form as long as it meets HUD qualifications for verifying the need for special accommodations.**

If the landlord's accommodation or modification would be required in order for the applicant/resident to have equal opportunity to use and enjoy the leased premises or the public or common use areas, the accommodation or modification may be granted. Accommodation or modification is not required of the landlord if the request is not reasonable (i.e., undue financial burden or fundamental change to the premises).

The applicant/resident named here has made what appears to be a reasonable request and has authorized your release of the requested supporting information. We would appreciate your prompt response to the questions on the reverse side of this letter. If you have questions, please contact us using the information below. Thank you for your cooperation.

LANDLORD INFORMATION (TO BE COMPLETED BY LANDLORD)

Landlord Name: _____

Landlord Address: _____

Landlord Phone: _____ FAX: _____

Landlord email: _____

The following accommodation(s)/modification(s) has/have been requested to provide the applicant/resident equal opportunity to use and enjoy the landlord's housing:

_____

_____

_____

_____

RENTER INFORMATION (TO BE COMPLETED BY APPLICANT/RESIDENT)

Applicant/Resident Name: _____

Applicant/Resident Current Address: _____

If different, name of person requiring accommodation: _____

If applicable, applicant's relationship to person: _____

I hereby authorize release to the landlord all information relevant to the requested accommodation/modification:

_____ _____

Applicant/Resident Signature Date

Verification by Physician or Other Qualified Professional of Disability Requiring Reasonable Accommodation/Modification to Housing Policies

THE FOLLOWING TO BE COMPLETED BY PHYSICIAN (OR OTHER QUALIFIED PROFESSIONAL)

1. Based upon your knowledge, does the above-named applicant/resident have a physical or mental impairment which substantially limits one or more major life activities?

Yes [ ] No [ ]

2. The major life activity substantially limited is (check all that apply):

☐ **Caring for oneself**	☐ **Seeing**	☐ **Breathing**
☐ **Performing manual tasks**	☐ **Learning**	☐ **Speaking**
☐ **Walking**	☐ **Working**	☐ **Hearing**
☐ **Operation of musculoskeletal system**		☐ **Social interaction**

☐ **Other (please specify)**

_____

3. Does the applicant/resident have a disability-related need for the requested accommodation(s)/ modification(s) based on the physical or mental impairment?

Yes [ ] No [ ]

4. Other comments (please do not provide information that is not directly relevant to the request for accommodation(s)/ modification(s)):

_____

_____

CERTIFICATION: I certify that the information provided above represents my professional judgment and is true and correct to the best of my knowledge and belief.

Name of Physician or other qualified professional: _____

Title and Practice Area: _____

Phone Number: _____

Address: _____

_____ _____

Signature of Physician or Professional Date