Texas General Land Office
Community Development and Revitalization
Form 14.27 Verification of Disability

Program Information		
Program:	**Disaster:**	
Vendor:	**Case Manager Name:**	

Applicant Information		
Applicant Name(s):		
Application ID:		
Applicant Physical Address:		
City:	**State:**	**ZIP Code:**

Household Member Name

A separate form must be completed for each household member in need of accommodation.

Household Member Name:

Instructions

In order to render assistance to the named household member requesting reasonable accommodations to the design of the Project home, the GLO must verify the need for the accommodations as early in the application process as practicable. A need for a reasonable accommodation may be verified through observation, disclosure of the receipt of federal disability benefits, or certification of the need by a medical professional. Please select the most appropriate statement(s) regarding a reasonable accommodation request below.

Method of Verification of Disability

To be completed by Case Manager, if applicable.

☐	**Observable Impairment** The household member named above is observed to have an impairment that requires a reasonable accommodation to the construction of the Project home.
☐	**Receipt of Federal Disability Benefits** The household member named above receives one of more of the following federal disability benefits and requires reasonable accommodation(s) to the construction of the Project home. *(Supporting documentation must be submitted to the GLO for review.)* ☐ Disability-Related Social Security ("SSDI") ☐ Supplemental Security Income ("SSI") ☐ Veterans' Administration ("VA") ☐ Other: _____
☐	**Certification from a Medical Professional** The household member named above has a note from a medical professional that confirms the need for reasonable accommodation(s) to the construction of the Project home. (*The note from the medical professional must be submitted to the GLO for review and the medical professional must sign this form.)*

Construction Modifications

This section of the form specifies construction modifications necessary to accommodate the named household member's use of the Project home. *(See the end of the form for examples of accommodations.)* The Case Manager will inform the named household member or their designated representative (if household member is unable to sign on their own behalf) of the package(s) described below that apply to the household member's accommodation needs. The household member or their representative may elect to accept or opt out of the available accommodations in the identified package(s). Please indicate acceptance of accommodations by checking the applicable boxes below. If a required accommodation is not listed in the identified package(s), then please describe the requested accommodation in the "Other" section.

Package 1: Cane/Walker or Fall Risk

☐ Vinyl flooring in all rooms except bathroom(s) (overrides carpet if selected on style selection sheet)
☐ Bathroom Modifications (☐ Primary or ☐ Secondary/Guest – *Select only one*)
- ☐ Grab bars around toilet
- ☐ Modified bathroom/shower (*Select only one*)
  - ☐ HC–2 Standard bathtub/shower with vertical grab bar outside of shower
  - ☐ HC–3 Standard bathtub/shower with grab bars, fold-up seat, and shower wand

Package 2: Standard Sized Wheelchair

☐ Accessible peephole on exterior doors (lowered to accommodate wheelchair height)
☐ Vinyl flooring in all rooms except bathroom(s) (overrides carpet if selected on style selection sheet)
☐ Kitchen Modifications
- ☐ Accessible microwave (located on countertop instead of above range)
- ☐ Range with accessible controls
- ☐ Accessible switches (within reach from wheelchair)
- ☐ Accessible sink (cabinet storage under sink removed to accommodate standard wheelchair)
- ☐ Lowered countertops to accommodate standard wheelchair height (no higher than 34 inches)

☐ Bathroom Modifications (☐ Primary or ☐ Secondary/Guest – *Select only one*)
- ☐ Accessible vanity (cabinet storage under sink removed to accommodate standard wheelchair)
- ☐ Lowered countertops to accommodate standard wheelchair height (no higher than 34 inches)
- ☐ Accessible medicine cabinet (within reach from wheelchair)
- ☐ Grab bars around toilet
- ☐ Modified bathroom/shower (*Select only one*)
  - ☐ HC–4 Roll-in shower with grab bars, fold-up seat, and shower wand
  - ☐ HC–5 Low-step shower with grab bars, fold-up seat, and shower wand

Package 3: Oversized and/or Motorized Wheelchair

☐ Accessible peephole on exterior doors (lowered to accommodate wheelchair height)
☐ Vinyl flooring in all rooms except bathroom(s) (overrides carpet if selected on style selection sheet)
☐ Structurally enhanced flooring system (for elevated homes only)
☐ Widened doorways and hallways (no more than 48 inches and only if required to accommodate size of wheelchair)
☐ Kitchen Modifications
  ☐ Accessible microwave (located on countertop instead of above range)
  ☐ Range with accessible controls
  ☐ Accessible switches (within reach from wheelchair)
  ☐ Accessible sink (cabinet storage under sink removed to accommodate standard wheelchair)
  ☐ Lowered countertops to accommodate standard wheelchair height (no higher than 34 inches)
☐ Bathroom Modifications (☐ Primary or ☐ Secondary/Guest – *Select only one*)
  ☐ Accessible vanity (cabinet storage under sink removed to accommodate standard wheelchair)
  ☐ Lowered countertops to accommodate standard wheelchair height (no higher than 34 inches)
  ☐ Accessible medicine cabinet (within reach from wheelchair)
  ☐ Grab bars around toilet
  ☐ Modified bathroom/shower (*Select only one*)
    ☐ HC–4 Roll-in shower with grab bars, fold-up seat, and shower wand
    ☐ HC–5 Low-step shower with grab bars, fold-up seat, and shower wand

Package 4: Hearing or Visual Impairment

☐ Audible/visible doorbell alert in living area and primary bedroom
☐ Strobe light alerts linked to fire alarms in living area and primary bedroom

Other

List all additional reasonable modifications to the construction of the Project home that are supported by a note from a medical professional (e.g. additional lighting, lift instead of ramp, remote controlled lighting). Also list any specific details not captured in the packages above (e.g. standard bathtub/shower with vertical grab bar instead of HC–4 or HC–5).

Household Member Authorization to Release Medical Information

The medical professional identified herein has knowledge that the named household member has a need for one or more construction modifications necessary to accommodate the named household member's use of the Project home that affect the household's participation in the Program. To assist in verifying the need for the requested reasonable accommodation(s), the GLO must receive confirmation of the need and other requested information from the identified medical professional. The GLO or Vendor may request from the medical professional only the minimum information necessary to determine whether the person requesting the modifications requires accessibility modifications. Neither the GLO nor the Case Manager may ask about the nature of an individual's disability, and medical professionals should not disclose specific details or diagnoses. **CONSENT OF THE HOUSEHOLD MEMBER OR THEIR REPRESENTATIVE TO THE RELEASE OF REQUESTED INFORMATION FROM THE MEDICAL PROFESSIONAL IS NOT A CONDITION OF ASSISTANCE TO THE PROJECT UNDER THE PROGRAM.**

By my signature below, I authorize the medical professional identified herein to release information requested herein to the GLO or its Vendor.

Household Member (or Representative) Printed Name:	**Date:**
Household Member (or Representative) Signature: Print and add signature in designated spot.	

Medical Professional Confirmation

The GLO has a contractual obligation under the United States Department of Housing and Urban Development Community Development Block Grant Disaster Recovery Program ("Program") to verify the need for modifications to the home that exceed ADA 2010 construction standards. The household member named above or their representative has asserted that the household member has a disability-related need for one or more reasonable accommodations that must be documented by a medical professional. By their signature above, the named household member or their representative has lawfully consented to the release by the medical professional to the GLO of the following confirmation regarding the requested accommodation(s) and of information requested in this form. All information provided by a medical professional will be used solely to verify need. Neither the GLO nor its representatives may ask about the nature of an individual's disability, and medical professionals should not disclose specific details or diagnoses.

By my signature below, I confirm that, in my opinion as a medical professional, the accommodations listed in the Construction Modifications section are necessary to facilitate the use of the Project home by the household member named above. I understand that providing false representations herein constitutes an act of fraud and that submitting false, misleading, or incomplete information may result in the Project household's ineligibility to participate in the Program.

Warning: Any person who knowingly makes a false claim or statement to HUD or causes another to do so may be subject to civil or criminal penalties under 18 U.S.C. 287, 1001 and 31 U.S.C. 3729.

Medical Professional Printed Name:	**Date:**
Medical Professional Title:	
Medical Professional Signature: Print and add signature in designated spot.	

Verification

By my signature below, I have read and understand the information provided in this form and verify the information provided by me herein is true and correct. I understand that providing false representations herein constitutes an act of fraud and that submitting false, misleading, or incomplete information may result in the Project household's ineligibility to participate in the Program.

Warning: Any person who knowingly makes a false claim or statement to HUD or causes another to do so may be subject to civil or criminal penalties under 18 U.S.C. 287, 1001 and 31 U.S.C. 3729.

Signatures

Household Member (or Representative) Printed Name:	**Date:**
Household Member (or Representative) Signature: Print and add signature in designated spot.	
Applicant Printed Name:	**Date:**
Applicant Signature: Print and add signature in designated spot.	
Applicant Printed Name:	**Date:**
Applicant Signature: Print and add signature in designated spot.	
Case Manager Printed Name:	**Date:**
Case Manager Signature: Print and add signature in designated spot.	

ACCESSIBLE BATH STYLE OPTIONS

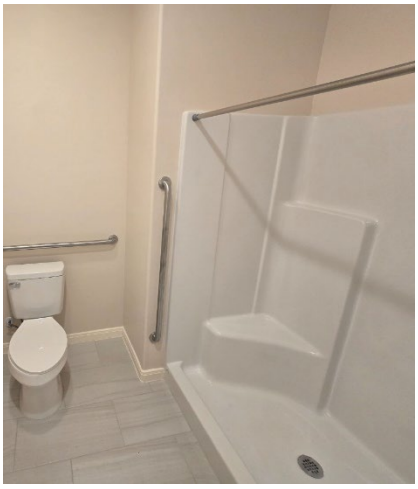
Final design, color, or layout of amenities may vary from those shown below. HC designates "Handicap" options.

HC–2

HC–3

HC–4

HC–5



ACCESSIBLE BATHROOM AMENITY OPTIONS

Final design, color, or layout of amenities may vary from those shown below.

Grab Bars Around Toilet

Accessible Bathroom Vanity

ACCESSIBLE BATH AMENITY OPTIONS CONT.

Final design, color, or layout of amenities may vary from those shown below.

Accessible Medicine Cabinet

ACCESSIBLE KITCHEN STYLE AND AMENITY OPTIONS

Final design, color, or layout of amenities may vary from those shown below.

Accessible Kitchen Sink

Range with Accessible Controls

ADDITIONAL AMENITY OPTIONS

Final design, color, or layout of amenities may vary from those shown below.

Strobe Light Alert