Request for a Service or Companion Animal

Pursuant to the rules governing the Fair Housing and the Americans with Disabilities Acts, a request is hereby made for the reasonable accommodation to allow a service or a companion animal to reside with the undersigned in the leased premises. Upon fulfilling the requirements listed below, the animal may reside in the premises and no additional lease fee or deposit will be assessed. However, the undersigned and other tenants residing therein will still be responsible for damages and for actions of the animal.

Check One		
		The animal I am requesting is a service animal. I acknowledge that such animal has received specific training and certification to assist persons who are either blind, hearing impaired, physically disabled, or otherwise disabled. The disabled person for whom the service animal is necessary qualifies under the appropriate definitions of a handicap pursuant to the Fair Housing Act and is listed and/or signed on the residential rental agreement.
		The animal I am requesting is a companion animal. I understand that I must meet the definition of having a handicap as provided in the Fair Housing Act which is as follows: "Handicap" means, 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 us of or addiction to a controlled substance. AND the companion animal may be necessary to afford me an equal opportunity to use and enjoy the premises. In order to insure that all disabled tenants obtain the accommodation that is requested for a companion animal, the following forms must be completed and returned: Animal Identification Form Medical Request Form Affidavit and Request for Companion Animal
Applicant's Name	;	
Premises Address		
Dated		Signature of Applicant



Animal Identification Form

Type of animal		Breed		
Age	Approximate Weight	Color		
Describe any sp	pecial training or certifications			
	nme			
Is the animal cu	errent on its shots and vaccination	s as suggested by its veterinarian	n?	
	ever been reported to authorities If yes, please provi	-	incident or for	
Animals m	nay not be in the common areas	of the community unless on a	leash or an	
	approved device based upor	the animal's certification.		
	Animals may be restric	ed from specific areas.		
The animal's	owners are responsible for clea	ning up after the animal and f	or any damage	
	done by th			
	may not disturb the peaceful a			
The C	ommunity may have other regu	lations and rules relating to a	nimals.	
I have read the	e rules and regulations concerning community) and a		policies of the	
Residen	t's signature	Dated		



Medical Request for Companion Animal

Name of Person making Request
A request has been made to allow a companion animal to reside with the above named individual. Such request has been made pursuant to the Fair Housing Act. In order to qualify for a companion animal exemption to the normal rules of the community, the person making the request must qualify as handicapped as defined , which is:
"Handicap" means, 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 us of or addiction to a controlled substance.
Additionally, the companion animal must assist the person in dealing with the disability.
Much like a prescription, this request is made because of the medical provider's opinion that the companion animal may be necessary to afford the disabled person an equal opportunity to use and enjoy the leased premises. With this request and upon approval, the management of the premises must allow the animal on the premises and may be prohibited from charging normal pet rent or other fees normally charged to persons with pets. Companion animals are not pets but animals that are determined by competent professionals to be an important and necessary part of treatment or assistance of a disability/handicap.
Doctor's Name Telephone number
I certify that I have sufficient information and have consulted with the Patient in order to make a diagnosis. I certify that the above named person is handicapped as defined above and that the animal described below is, in my professional opinion, necessary to afford an equal opportunity to use and enjoy the leased premises. I agree that I will be willing to testify of these representations if called upon in a Court of law.
Prescribed Animal's Description
Expiration Date of this Certification
Date Physician's Signature



Affidavit and Request for Companion Animal

The undersigned does hereby request a companion animal and does hereby swear and state as follows:

1. Handicap Definition	I am aware of the requirements of the Fair Housing Act and its definitions which include:
"Handicap'	' means, 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 us of or addiction to a controlled substance.
2. Qualification	Pursuant to the definition above, I do qualify and am or have been under the
	care of a licensed medical professional for my disability; or have been so diagnosed with a permanent disability to no longer require medical
	supervision
3. Impairment	I represent that the requested companion animal is necessary to provide assistance with my disability.
The anticipated leng	th of this disability is
My primary care physician i	s Dr whose telephone number is
4. Request	I do hereby request that I be able to reside with a companion animal at the premises below. I certify that the statements herein are true and have provided herewith an Animal Identification Form and a Medical Request for a Companion Animal. I agree that the only animal I will keep for this purpose is listed therein and that I will abide by the rules and regulations of the community regarding animals. I understand that I will not have to pay additional costs or fees for the companion animal but will be responsible for any damage caused. I request that my medical professional provide any and all information to my housing provider to assist in making this determination. I hereby waive all my rights under the HIPPA laws and agree to indemnify and hold harmless both the medical professionals and the housing provider from any liability relating to the release of my medical
	information.
Applicant's Name	
Premises Address	
Dated	



Signature of Applicant

Limited HIPAA Release to Authorized Persons

(Patient Name) Social Security Number
(Patient Name)Social Security Number
This authorization specifically applies to all health care providers and any records that may be requested. The purpose of this disclosure shall include verification and obtaining by the Authorized Person(s in making determinations relating to any Reasonable Accommodation request made during tenancy and the information to be obtained is limited to information relating to that request and the verification necessary to give the Authorized persons sufficient information to make the determination. This release is limited to such information.
I understand that, with certain exceptions, I have the right to revoke this Authorization at any time. If I want to revoke this Authorization, as well as the exceptions to my right to revoke will be performed in accordance with applicable federal law and any applicable policy of my health care provider.
I understand that, I may refuse to sign this Authorization. I also understand that failure to sign this
Authorization may prevent the granting of any Reasonable Accommodation requested. I understand that, once information is disclosed pursuant to this Authorization, it is possible that I will no longer be protected by applicable federal medical privacy law and could be re-disclosed by the person or agency that receives it, however, I do not authorize such secondary disclosure. The authority given to said Authorized Person(s) shall supersede any prior agreement that I may have made with my healthcare providers to restrict access to or disclosure of my individually identifiable health information. The authority given has no expiration date and shall expire only in the event that I revoke the authority in writing and deliver it to my health care provider.
I have read and understand the information in this authorization form.
Signature: Date:
Print Name:

