homeforward

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Home Forward Property Management: Phone: 503-280-3750 / TTY: 503-802-8554 / Fax 503-280-3766

PRIORITY VERIFICATION REQUIRING UNIT WITH ACCESSIBLE FEATURES

Home Forward provides priority placement on its housing waitlists for households that require a unit with accessible features. There are varying degrees of "accessibility" features. For example, some applicants who use wheelchairs or scooters may require certain accessibility features. However, **this priority is specifically for households that require a unit with one or more of the following features:**

Physician/Licensed Professional should check off the features necessary for patient, and initial on the blank

- ☐ Kitchen with accessible features including: lowered/ roll-under cabinets and sinks, stove with controls on the front. _____
- ☐ Bathroom with accessible features including: Transfer bench and/or roll-in shower, grab bars in the shower and commode areas, and lowered/ roll-under sinks. _____
- ☐ Closet storage with lowered shelving and bars. _____
- ☐ In all rooms: Doorways that are at least 36 inches wide, lowered light switches because turning lights off/on is typically done from a sitting position, 60-inch turn radius and lever operated handles. _____

Other needs/features (please specify)_____

_____

APPLICANT AUTHORIZATION

I, _____, authorize the release of this information to Home Forward.

Signature of Head of Household:_____ Date:_____

HOUSEHOLD MEMBER OF CONCERN

Name:_____ Signature:_____

Social Security Number:_____ Date of Birth:_____

Mailing Address:_____

Phone Number:_____ Date:_____

PHYSICIAN / LICENSED PROFESSIONAL'S CERTIFICATION

It is my diagnosis that _____, a member of the above household requires a unit with the features that **I have checked off and initialed above**.

Print Name: _____ Title: _____

Signature: _____ Date: _____

Address: _____

Phone: _____ Fax: _____

Completed by Home Forward Staff *Note: *Physician's certification valid for 12 months from date signed**

Name of Person Spoken to: _____ Title: _____

Phone #: _____ Date and Time Verified: _____ Physician's office certifies that form is authentic? ○ Yes ○ No

Verification conducted by: _____

Staff Signature *Date*

(REV 6/17)