

EXHIBIT A

Request for Reasonable Accommodation or Modification Form

REQUEST FOR REASONABLE ACCOMMODATION/MODIFICATION

The purpose of this form is to facilitate a request for a reasonable accommodation or modification. The RA Coordinator will assist the requestor in filling out the form. Any requests made orally have been transcribed by the RA Coordinator onto this form.

DATE: _____

What is the person with a disability's relationship to the Co-operative?

- Member Prospective Member Individual Whose Name is on the Occupancy List
 Resident Guest

**Contact Information for
Individual with a Disability:**

Name: _____

Address: _____

Telephone Number: _____

Email Address: _____

**Contact Information for
Requestor (if not individual
with a disability)**

Name: _____

Address: _____

Telephone Number: _____

Email Address: _____

**Contact Information for
Member or Prospective
Member**

Name: _____

Address: _____

Telephone Number: _____

Email Address:

**Accommodation/Modification
Proposed (including the barrier
to enjoyment of premises or
common use areas)**

**Relationship Between the
Disability and the Need for the
Proposed Accommodation:**

ADDITIONAL INFORMATION (CASE BY CASE BASIS)

**Supporting Information to
Verify the Disability (if not
apparent):**

Verifying Entity's Information		
Name _____		
Address _____		
Phone No. _____		
Email _____		
Affiliation _____		
Date: _____		
If requesting a reasonable modification, I agree and acknowledge I will be responsible for all expenses associated with making the modification.		
<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;">_____ Signature of Requestor</td> <td style="width: 50%; border: none;">_____ Date</td> </tr> </table>	_____ Signature of Requestor	_____ Date
_____ Signature of Requestor	_____ Date	
If requesting a reasonable modification to the dwelling unit, I agree and acknowledge I will be responsible for all expenses for and restoration of the dwelling unit to its condition prior to the reasonable modification.		
<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;">_____ Signature of Requestor</td> <td style="width: 50%; border: none;">_____ Date</td> </tr> </table>	_____ Signature of Requestor	_____ Date
_____ Signature of Requestor	_____ Date	
Reasonable Accommodation Coordinator Determination and Accommodation Granted _____		

Date of Determination _____
Date Accommodation Provided _____

EXHIBIT B

Confirmation of Disability and Need for Reasonable Accommodation or Modification

CONFIRMATION OF DISABILITY AND NEED FOR ACCOMMODATION OR MODIFICATION

DATE:

TO:

MEDICAL PROFESSIONAL'S NAME

ADDRESS

FROM:

Greenbelt Homes, Inc. ("GHI")

Name of Person with Disability

Address

The person named above has asked GHI to provide the following reasonable accommodation or modification because of a disability:

Under federal law, if an individual requests a reasonable accommodation or modification because of a disability, we must consider the request. To do this, we must verify that the individual qualifies as disabled under federal law and that the requested accommodation is reasonable. You can assist us by answering the questions on this form and returning it to us in the stamped, self-addressed envelope enclosed for this purpose. The requestor's consent to this release of information is set forth below.

DEFINITION OF "DISABLED"

Under federal law, an individual is disabled if they have a physical or mental impairment that substantially limits one or more major life activities, has a record of such an impairment, or is regarded as having such an impairment. The term "physical or mental impairment" includes, but is not limited to, such diseases and conditions as orthopedic, visual, speech, and hearing impairments, cerebral palsy, autism, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, Human Immunodeficiency Virus infection, developmental disabilities, emotional illness, drug addiction, and alcoholism. This definition doesn't include any individual who is a drug addict and is currently using illegal drugs, or an alcoholic who poses a direct threat to property or safety because of alcohol use.

INFORMATION REQUESTED

- 1. Is the person identified above disabled, as defined above? Yes No
- 2. In your professional opinion, is an accommodation/modification necessary for the person to have the same opportunity that an individual without a disability would have to use and enjoy their living quarters or common use areas of the Cooperative?
 Yes No

Medical Specialty (e.g., orthopedics, cardiology, etc.)

Name of Medical Practice

MEDICAL PROFESSIONALS SIGNATURE

MEDICAL LICENSE #

RELEASE

TO THE REQUESTOR:

YOU DO NOT HAVE TO SIGN THIS FORM IF THE NAME OR ADDRESS OF EITHER GHI OR THE LICENSED MEDICAL PROFESSIONAL IS LEFT BLANK.

RELEASE: I hereby authorize the release of the requested information. Information obtained under this consent is limited to information that is no older than 12 months. There are circumstances that would require GHI to verify information that is up to five years old, which would be authorized by me on a separate consent, attached to a copy of this consent.

**REQUESTOR'S
SIGNATURE**

DATE