Cresthaven/Gately Section 5.
c/o Sea Breeze CMS
4227 Northlake Blvd,
Palm Beach Gardens, FL 33410
561-626-0917, info@seabreezecms.com

Request Emotional Support and/or Service Animal (ESSA)

To accept an Emotional Support and/or Service Animal (ESSA) on-site you may utilize this form to request that Cresthaven/Gately Section 5. Provide permission to you so that you may utilize your residence or any of the Association's common elements.

For purposes of this form, please refer to the "Questionnaire" section below to determine whether you are a "qualified individual with a disability".

You must date and sign your name of this form and return the form to the property manager's office. If you need assistance in understanding whether you are a "qualified individual with a disability" or if you need assistance in completing this form, please contact your local Housing Authority.

_____ _____
Date of Request Social Security Number

_____ _____
Name of Applicant/Resident/Participant Telephone Number

_____ _____
Address City/State/Zip Code

Questionnaire

1. I am requesting the following ESSA: _____
_____
_____
_____

2. My reason(s) for requesting this ESSA is: _____
_____
_____
_____

OR

_____ (Check if applicable)
A physician, licensed health care professional, professional representing a social service agency, disability agency or clinic may provide verification of your disability.

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Dear Resident/Applicant:

You have indicated that you, need an ESSA because of a disability in connection with a condominium unit located at Cresthaven/Gately Sec 5.

Enclosed is *Authorization for Release of Information* the perspective resident would need to complete this form.

Enclosed is *ESSA Request Verification* this form would need to be completed by your health care provider or other appropriate individual, clinic or agency

Cresthaven/Gately Sec 5. will use this information to evaluate your request. Cresthaven/Gately Sec 5. will keep this information confidential. If you choose not to authorize the release of this information, we may not be able to consider your reasonable accommodation request(s).

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Authorization for Release of Information

Household Member with Disability: _____

I hereby authorize _____ **[Insert name of health care provider or other appropriate documenting authority]** to consult with representatives of the Cresthaven/Gately Sec 5. in writing, in person, or by telephone concerning the physical or mental impairment(s) that I assert to qualify as an individual with a disability for the sole purpose of this ESSA request.

I hereby authorize the release of information to the Cresthaven/Gately Sec 5. regarding the request for ESSA described on this form. This release shall constitute a limited authorization for the release of information, as described below.

This Authorization solely authorizes the release of information necessary to verify the following:

1. **Documentation necessary to verify that the above-named individual meets the definition of a "qualified individual with a disability", as defined below;**
2. **A description of the needed ESSA; and,**
3. **A description of the identifiable relationship between the individual's disability and the requested ESSA.**

For purposes of this Release, a "Qualified Individual with a Disability" is defined as person who has a physical or mental impairment that:

1. Substantially limits one or more major life activities
2. Has a record of such an impairment
3. Is regarded as having an impairment

"A Physical or Mental Impairment" is defined as:

1. Any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the body systems including, but not limited to: neurological, musculoskeletal, special sense organs, respiratory, and speech organs; **or**

2. Any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness and specific learning disabilities.

 INFORMATION TO BE PROVIDED BY PERSPECTIVE RESIDENT

The term "Physical or Mental Impairment" includes, but is not limited to, such diseases and conditions as visual, speech and hearing impairments, epilepsy, multiple sclerosis, cancer, etc.

"Major Life Activities" include functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.

"Has a Record of Such an Impairment (mental or physical)" means has a history of, or has been misclassified as having, a mental or physical impairment that substantially limits one or more major life activities.

"Is Regarded as Having an Impairment" means:

1. Has a physical or mental impairment that does not substantially limit one or more major life activities, **but** is treated by a recipient as constituting such a limitation.
2. Has a physical or mental impairment that substantially limits one or more major life activities **only as a result of** the attitudes of others toward the impairment.
3. Has none of the impairments defined by Section 504's definition of "physical or mental impairment, **but** is treated by a recipient as having such an impairment.

In addition, I authorize _____ **[Insert name of health care provider or other appropriate documenting authority]** to provide only documentation that is necessary to verify that I meet the definition of a "Qualified Individual with a Disability", as defined above. This Authorization for Release of Information should only seek information that is necessary to determine if the requested reasonable accommodation is needed because of a disability.

This Authorization does **not** authorize Cresthaven/Gately Sec 5. to examine my medical records, including diagnosis or test result(s); nor does this authorize the release of detailed information about the nature or severity of my disability. Any information or documentation released as a result of this Authorization shall be kept confidential and will not be shared with anyone unless required to make or assess a decision to grant or deny a reasonable accommodation request.

I hereby authorize the release of the requested information. Information obtained under this consent is limited to information that is no older than twelve (12) months.

_____
Date

_____
Signature of Perspective Resident

 INFORMATION TO BE PROVIDED BY PERSPECTIVE RESIDENT

PLEASE PROVIDE THE FOLLOWING INFORMATION:

(1) Name of Health Care Provider/Documenting Authority:

_____

(2) Address of Health Care Provider/Documenting Authority:

_____

_____

(3) Telephone/ Facsimile Number of Health Care Provider/Documenting Authority:

_____ _____

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 INFORMATION TO BE COMPLETED BY PROVIDER

ESSA Request Verification

Date: _____

To: _____

Health Care Provider's Name: _____

Health Care Provider's Address: _____

_____

Re: Request for Reasonable Accommodation

Member's Name: _____

Property Address: _____

_____

Under normal circumstances, our policies would require us to deny the request. However, under federal law, if an individual with disabilities requests accommodation to that disability, we must consider the request. To do this, we must verify that the individual qualifies as disabled under federal law and requires the accommodation in order to have an equal opportunity to use and enjoy his/her home.

We would appreciate your cooperation in answering the questions on this form and returning it to the address listed above. Enclosed is a stamped, self-addressed envelope for this purpose. **[Insert name of Resident]** _____ has consented to this release of information, as shown on the following page.

DEFINITION OF "DISABLED"

A person is considered handicapped under state and federal laws if he or she has, a physical or mental impairment which substantially limits one or more of his or her major life activities such as seeing, hearing, walking, speaking, learning, breathing, eating or

performing manual tasks; a record of having such impairment; or is regarded as having such impairment.

In a joint statement in 2004, the U.S. Department of Housing and Urban Development (HUD) and the Justice Department explained that physical or mental impairments include, but are 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, HIV, mental retardation, emotional illness, drug addiction (excluding an addiction caused by current, illegal use of a controlled substance) and alcoholism.

INFORMATION REQUESTED

1. Is **[_____]** disabled as defined on the following page?

   [ ] Yes [ ] No

2. If you answered "Yes" to question number one, can **[_____]** condition be treated to prevent any substantial limits in any of his/her major life activities?

   _____

   _____

3. What "major life activities" are limited by this disability?

   _____

   _____

4. How will the Association's granting of the reasonable accommodation help **[_____]**?

 INFORMATION TO BE COMPLETED BY PROVIDER

5. Please demonstrate the relationship between the person's disability and the need for the requested accommodation.

   _____

6. In your professional opinion, does **[_____]** need the accommodation requested in order to have the same opportunity that a non-disabled individual has to use and enjoy his/her home?

   [ ] Yes [ ] No

7. Since what date has **[_____]** been under your care?

   _____

8. How many times have you seen **[_____]** as a patient, and on what dates? (Please limit your response to the last twelve (12) calendar months).

   _____

NAME AND TITLE OF PERSON SUPPLYING INFORMATION:

_____

FIRM/ ORGANIZATION:

_____

Would you be willing to testify in any court action or related proceeding as to **[_____]** need for the requested accommodation?

[ ] Yes [ ] No

HEALTH CARE PROVIDER'S SIGNATURE: _____

MEDICAL LICENSE NUMBER (IF PHYSICIAN): _____

DATE: _____