PRAIRIE
Property Management

3280 Veterans Blvd S., Suite 100
Fargo ND 58104
701-356-3085
Fax: 701-3556-8340
Prairiepropertymgt.com

ASSISTANCE/ESA ANIMAL VERIFICATION FORM

This form is to be completed by a licensed professional specializing in the medical condition.

Please provide the following information concerning my request to my housing provider for a service animal.

1. Name of Individual Needing Accommodation/Modification: _____
2. Name of Treating Physician or Other Professional: _____
3. Title/Credentials: _____
4. Area of Specialty: _____
5. Address of Clinic: _____
6. Phone: _____
7. Email: _____

In accordance with the signed authorization provided on this form, please complete the following <u>WITHOUT DISCLOSING ANY DIAGNOSIS-SPECIFIC DETAILS</u>, in your professional opinion:

1. Does the above Individual have a physical or mental impairment as defined by the Americans with Disabilities Act (ADA)?

   YES NO I DON'T KNOW

2. Does the above Individual's impairment(s) substantially limit at least one major life activity or major bodily function?

   YES NO I DON'T KNOW

3. Does the above Individual need the animal(s) because it provides therapeutic emotional support to alleviate a symptom or effect of the disability of the above Individual, and not merely as a pet?

   YES NO I DON'T KNOW

4. What type of animal is required for the disability? If more than one, please identify the particular benefit of each animal: _____
   _____

5. Do you have a personal medical relationship with the above Individual involving the provision of health care or disability-related services?

   YES NO I DON'T KNOW

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If you answered yes to preceding question, please provide the information below:

a. How long have you been familiar with the above Individual's disability? _____

_____

b. On what date did you first treat the above Individual for the disability? _____

_____

c. How many times have you treated the above Individual in-person for the disability?
    a. 0
    b. 1
    c. 2-4
    d. 5+

d. Do you have an ongoing treatment plan for the above Individual?
    a. Yes
    b. No

e. In what manner have you treated the above Individual for the disability? Circle all that apply.
    a. Email
    b. Phone
    c. Telehealth Visit
    d. In-person meeting

f. What medical information has been reviewed to determine the Individuals need for an assistance animal?_____

g. Do you believe this Individual poses a threat to themselves or others?

YES NO I DON'T KNOW

6. Please list any additional accommodations that you believe satisfy the Individual's disability-related needs.

_____

_____

Provider Signature: _____ Date: _____

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AUTHORIZATION FOR RELEASE OF INFORMATION

Date: _____

Resident/Applicant Name: _____

Resident/Applicant Address: _____

_____

Name of Person Needing Accommodation/Modification: _____

I authorize the above physician or other professional to provide the information requested in this verification form, as well as any additional information necessary to help verify the need for an assistance animal. **THIS IS NOT A RELEASE OF MEDICAL RECORDS.** I understand that I have the right to revoke this authorization at any time by sending written notification to the above physician or other professional. Written revocation will be effective upon receipt but will not apply to information already released in response to this authorization. I understand that once the requested information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure or release and may no longer be protected by federal or state law.

Applicant/Resident Signature: _____ Date: _____

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*North Dakota Residents: Please review North Dakota Century Code §47-16-07.6, stating that a penalty may be imposed if an Individual knowingly makes a false claim that a pet is a service animal.

*Minnesota Residents: Please review Minnesota Statute 609.833, stating that an Individual intentionally misrepresenting a service animal may be guilty of a misdemeanor.

APPLICANT/RESIDENT INFORMATION

1. On what date were you first treated by the listed physician or other professional? _____

   _____

2. How many times have you been treated by the listed physician or other professional? ___

   _____

3. Did you seek a reimbursement from your insurance company for these treatments? ____

   _____

4. Did you meet with your physician or other professional via telehealth, email, phone, or in-person? _____

5. Where did you find your treating physician or other professional listed above? _____

   _____

Applicant/Resident Signature: _____ Date: _____

****IF YOU HAVE ANY QUESTIONS, PLEASE REFER TO THE ATTACHED NOTICE FHEO-2020-01 AND FACT SHEET FROM THE U.S. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT TO CLARIFY THE RIGHTS AND OBLIGATIONS UNDER THE FHA REGARDING ASSISTANCE ANIMALS OR CONTACT YOUR LOCAL HUD OFFICE.****