

## FINDING OF DISABILITY AND NEED FOR ASSISTANCE ANIMAL

This form is used to make the required finding pursuant to Iowa Code section 216.8C.

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### TO BE COMPLETED BY PATIENT/CLIENT/REQUESTER

Patient/Client/Requester's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ E-mail: \_\_\_\_\_

I intend to request that \_\_\_\_\_ [name of housing provider] permit me to keep an assistance animal as a reasonable accommodation in housing for my disability. In connection with that application, I am requesting that you, my health care provider, complete this form regarding my disability.

\_\_\_\_\_  
Patient/Client/Requester's Signature

\_\_\_\_\_  
Date

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### TO BE COMPLETED BY HEALTH CARE PROVIDER/ LICENSEE

1. Does your patient/client identified above have a physical or mental condition that substantially limits a major life activity?  Yes  No

2. Does or would an assistance animal alleviate one or more of the symptoms or effects of the condition?  
 Yes  No

If yes, what particular assistance does the animal provide to your patient/client?

3. As the health care provider/licensee listed below, have you received a separate fee, additional fee, or other form of compensation solely in exchange for making this written finding?  Yes  No

4. This letter was issued on \_\_\_\_\_. It will expire after 12 months or at the expiration of the term of your patient/client's rental agreement, whichever is greater.<sup>1</sup>

By signing below, you certify you: 1) have had a relationship with the patient/client for at least thirty (30) days; 2) have met with the patient/client in person or by telemedicine, 3) are sufficiently familiar with the patient/client and their disability, prior to writing the finding, to make the finding; and 4) are legally and professionally qualified to make the finding.

Health Care Provider/Licensee's Name (printed): \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**This document may contain privileged and confidential information and/or protected health information intended solely for use by the recipient housing provider. Please exercise care to avoid dissemination.**

<sup>1</sup> Unless you as the health care provider/licensee provide a shorter expiration date.