Disability Verification Form

Revised 8.2016

Date of Verification: ______________________________

Last Name: ______________________________ First Name: ______________________________

Referring Agency: ______________________________ Case Manager: ______________________________

For the purpose of this program, the applicant/tenant must meet the following criteria: a) As a result of her/his disability, the need for treatment is expected to be of a long, continued, and indefinite duration; b) The disability substantially impedes her/his ability to live independently; and c) The disability is of such nature that it could be improved by more suitable housing conditions. If the participant is disabled by chronic problems with alcohol and/or drugs, the problematic use must have occurred for at least 12 months and caused serious difficulties in interpersonal relationships as evidenced by disruptions in employment, loss of housing, and/or loss of role in family structures or other important relationships.

Primary Disability:	**Secondary Disability:**
☐ Mental Health	☐ Mental Health
☐ HIV/AIDS	☐ HIV/AIDS
☐ Drug Abuse	☐ Drug Abuse
☐ Alcohol Abuse	☐ Alcohol Abuse
☐ Alcohol and Drug Abuse	☐ Alcohol and Drug Abuse
☐ Chronic Health Condition	☐ Chronic Health Condition
☐ Developmental Disability	☐ Developmental Disability
☐ Physical	☐ Physical
☐ Other (Please Specify): ____________________	☐ Other (Please Specify): ____________________

Disability Status:

☐ Currently receiving SSI/SSDI

☐ Not currently receiving SSI/SSDI

______________________________ ______________________________

Signature of Independently Licensed Clinician — Date

______________________________ ______________________________

PRINT name of person signing form — License Number

____

Title of person signing form

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