(NAME OF ORGANIZATION)

(ADDRESS) (PHONE NUMBER)
(FAX NUMBER)

VERIFICATION OF DISABILITY FOR HUD CoC-FUNDED PERMANENT SUPPORTIVE HOUSING

DATE: _____

TO: ATTN: (NAME OF STAFF MEMBER): _____
_____
_____

RETURN THIS VERIFICATION TO THE PERSON LISTED ABOVE

SUBJECT: Verification of Disability

Please note that professionals completing this form must be licensed by the State of Ohio to diagnose and treat the disability/disabilities documented below.

NAME:_____

ADDRESS:_____

This person has applied for housing assistance under a program of the U.S. Department of Housing and Urban Development (HUD). HUD requires the housing owner to verify all information that is used in determining this person's eligibility or level of benefits.
We ask your cooperation in providing the following information and returning it to the person listed at the top of the page. Your prompt return of this information will help to ensure timely processing of the application for assistance. Enclosed is a self-addressed, stamped envelope for this purpose. The applicant/tenant has consented to this release of information as shown below.

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RELEASE: I hereby authorize the release of the requested information to the provider identified above and to the Stark County HMIS. Information obtained under this consent is limited to information that is no older than 12 months. There are circumstances that would require the owner to verify information that is up to 5 years old, which would be authorized by me on a separate consent attached to a copy of this consent.

_____ _____
Signature Date

Note to Applicant/Tenant: You do not have to sign this form if either the requesting organization or the organization supplying the information is left blank.

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INFORMATION BEING REQUESTED

For each numbered item below, mark an "X" for all applicable items that accurately describes the severity and diagnosis of the person listed above.

1. i.) ☐ YES ☐ NO Has a disability that is expected to be long-continuing or of indefinite duration

ii.) ☐ YES ☐ NO Has a disability that substantially impedes the individual's ability to live independently

iii.) ☐ YES ☐ NO The disability could be improved by the provision of more suitable housing conditions

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iv.) a.) ☐YES ☐NO Has any of the following diagnoses; a physical, mental, or emotional impairment, including an impairment caused by post-traumatic stress disorder, cognitive impairments resulting from brain injury

b.) ☐YES ☐NO Has an impairment caused by alcohol or drug abuse

2. ☐YES ☐NO Has a developmental disability, as defined in Section 102(7) of the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C. 6001(8):

(1) A severe, chronic disability that -

i.) Is attributable to a mental or physical impairment or combination of mental and physical impairments;

ii.) Is manifested before the person attains age 22;

iii.) Is likely to continue indefinitely;

iv.) Results in substantial functional limitation in three or more of the following areas of major life activity;

(A) Self-care,
(B) Receptive and expressive language,
(C) Learning,
(D) Mobility,
(E) Self-direction,
(F) Capacity for independent living, and
(G) Economic self-sufficiency; and

v.) Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are of lifelong or extended duration and are individually planned and coordinated.

(2) An individual from birth to age 9, inclusive, who has a substantial developmental delay or specific congenital or acquired condition, many be considered to have a developmental disability without meeting three or more of the criteria describe above in (1) (i) - (v.) of the definition of "developmental disability, if the individual, without services and supports, has a high probability of meeting these criteria later in life.

3. ☐YES ☐NO An individual who has the disease of acquired immunodeficiency syndrome or any condition arising from the etiologic agency of acquired immunodeficiency syndrome, including infection with the human immunodeficiency virus.

☐ Please initial box to certify that you have made a diagnosis for the individual identified above and will maintain records of this information.

Print Name and Title of Person Certifying the Information	Firm/Organization	License Number(s) & State

Signature	Contact Tel Number	Date

PENALTIES FOR MISUSING THIS CONSENT: Title 18, Section 1001 of the U.S. Code states that a person is guilty of a felony for knowingly and willingly making false or fraudulent statements to any department of the United States Government. HUD and any owner (or any employee of HUD or the owner) may be subject to penalties for unauthorized disclosures or improper uses of information collected based on the consent form. Use of the information collected based on this verification form is restricted to the purposes cited above. Any person who knowingly or willingly requests, obtains, or discloses any information under false pretenses concerning an applicant or participant may be affected by negligent disclosure of information may bring civil action for damages and seek other relief, as may be appropriate, against the officer or employee of HUD or the owner responsible for the unauthorized disclosure or improper use. Penalty provisions for misusing the social security number are contained in the Social Security Act at 208 (a) (6), (7) and (8). Violations of these provisions are cited as violations of 42 USC 408 (a) (6), (7) and (8).

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