

Verification of Disability

I authorize (agency) _____ to obtain necessary information regarding my disability status or that of a member of my household:

XXX-XX-____

(Print) Disabled Household Member Relationship to Head/Applicant SSN (last 4 digits)

I understand that this information is to help me qualify for appropriate housing and supportive services. By signing below I authorize the release of this information.

Applicant Signature _____ Date _____

The above named person has applied for housing under a U.S. Department of Housing and Urban Development (HUD) program that requires verification of a disability under the applicable HUD definition. Please indicate which condition(s) you have diagnosed this person to have.

1. A condition that:

- Is expected to be long-continuing or of indefinite duration; **AND**
- Substantially impeded the person's ability to live independently; **AND**
- Could be improved by the provision of more suitable housing conditions; **AND**
- Is a physical, mental, or emotional impairment, including an impairment caused by alcohol or drug abuse, post-traumatic stress disorder, or brain injury.

2. A developmental disability (as defined in Section 102 of the Developmental Disability Assistance and Bill of Rights Act of 2000 (42 USC 15002)). Which means a severe, chronic disability of an individual that:

- Is attributable to a mental or physical impairment or combination of mental and physical impairments; **AND**
- Is manifested before the individual attains age 22; **AND**
- Is likely to continue indefinitely; **AND**
- Results in substantial functional limitations in three or more 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; (g) Economic self-sufficiency; **AND**
- Reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic services, or individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated. **OR**
- An individual from birth to age 9, inclusive, who has a substantial developmental delay or specific congenital or acquired condition, may be considered to have a developmental disability without meeting three or more of the criteria described above if the individual, without services and supports has a high probability of meeting those criteria later in life.

3. The disease of acquired immunodeficiency syndrome (AIDS) or any conditions arising from the etiological agent for acquired immunodeficiency syndrome, including infection with the human immunodeficiency virus (HIV).

Is not considered disabled according to the above definitions.

Please Print: THIS SECTION MUST BE COMPLETE TO BE VALID

Name of Certifying Official (print clearly)	
Title/License #/State Issued (print clearly)	
Office Address	
Telephone and Fax	

Your signature below certifies that the above named individual meets the disability definition indicated above AND you are professionally licensed by the state in which you practice to diagnose and treat the indicated disability.

Signature _____

Date _____

WARNING: It is unlawful to provide false information to the government when applying for federal public benefit programs per Section 1001 of Title 18 of the United States Code.

KHC Form HCA-123 (Rev. 8/14)

