Disability Verification:

Client Name: ______________________ Date: ___ / ___/_____ HMIS #: _________________

This form does NOT address a person's eligibility for Social Security Benefits; rather it only confirms that the person would benefit from housing due to a disability as defined by HUD (The Department of Housing and Urban Development).

Dear Provider: We appreciate your assistance verifying the disabling condition of this individual so we may document their eligibility for a supportive housing placement. If you have any questions about how to complete this document, please contact the worker listed below. Thanks so much for your assistance to secure housing for this individual.

Worker Name:
____

Worker Email:
____

Worker Phone:
____

THIRD PARTY VERIFICATION OF DISABLING CONDITION

Name and Credentials of Qualified Professional completing this Disability Verification Form (professional licensed by the State of Illinois to diagnose and treat the disabling condition):

Clinician's Name:

____

Clinician's Title:
____

Clinician's Address:
____

Clinician's License #:
____

Please complete this section for ALL clients:

DISABILITY DETERMINATION
To qualify for permanent supportive housing, a disabling condition must be determined, verified, and documented.

☐ This individual has a disability, as defined in 42 USC 423, which means:

- Inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months.

Please select one or more appropriate category of disability below, and check the appropriate supporting box(es) under each applicable disability type (Please note each disability type has different requirements, so please read the instructions carefully.):

☐ **Physical, Mental, or Emotional Disability**
583.5/42usc 11360(9)

To meet eligibility requirements, **ALL** boxes of this section must be checked:

This person has **a physical, mental, or emotional impairment** (which could include an impairment caused by alcohol or drug abuse) that:

☐ Is expected to be long-continuing or of indefinite duration;

AND

☐ Substantially impedes the individual's ability to live independently;

AND

☐ Is of such a nature that the ability to live independently could be improved by more suitable housing conditions

☐ **AIDS/HIV**
583.5/42usc 11360(9)

Check only **ONE** applicable box:

This person is afflicted with:

☐ Acquired Immunodeficiency Syndrome (AIDS)

OR

☐ Any conditions arising from the etiologic agent for acquired immunodeficiency syndrome, including infection with the human immunodeficiency virus (HIV).

☐ **Developmental Disability**
578.3

To meet eligibility requirements, **ALL** boxes of this section must be checked:

This person has a **severe, chronic disability** that:

☐ Is attributable to a mental or physical impairment or combination of 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** of the following areas of major life activity (at least 3 boxes must be checked):

- ☐ Self-care
- ☐ Learning
- ☐ Self-direction
- ☐ Economic Self-sufficiency
- ☐ Receptive and expressive language
- ☐ Mobility
- ☐ Capacity for independent living

AND

☐ This person needs a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated.

CLINICAL DIAGNOSIS

Disability (written diagnosis with diagnostic code): ________________________________

____

I, ____, have interviewed and observed this individual and have diagnosed the individual with the disabling condition(s) listed. I have also determined the individual's condition has been present since ____________________________________ and **limits the individual's ability** to work and/or perform one or more of the following activities of daily living for the following reasons:

____

____

____

____

_______________________________________ ____

____ ____________________
Signature of Qualified Professional Date