Coordinated Access
The Way Home Houston

VERIFICATION OF DISABLING CONDITION FOR SUPPORTIVE HOUSING

Applicant's Name: _____ DOB: _____

This form verifies that the applicant named above has a disabling condition necessary for determining eligibility for a HUD CoC Permanent Supportive Housing Program. A person shall be considered to have a disabling condition if he or she has one or more of the following:

1. A disability as defined in Section 223 of the Social Security Act;
2. A physical, mental, or emotional impairment which is:
    a. expected to be of long-continued and indefinite duration,
    b. substantially impedes an individual's ability to live independently, and
    c. of such a nature that such ability could be improved by more suitable housing conditions;
3. A developmental disability as defined in section 102 of the Developmental Disabilities Assistance and Bill of Rights Act;
4. The disease of acquired immunodeficiency syndrome or any conditions arising from the etiological agency for acquired immunodeficiency syndrome; **OR**
5. A diagnosable substance abuse disorder.

Diagnosis: _____

Printed Name of Physician or Licensed Professional: _____

License Number: _____

Agency or Clinic Name: _____

Phone Number: _____ **Fax Number:** _____

By signing below, you are verifying that this applicant has the condition as stated above & that you are qualified to make that diagnosis.

Signature/Credentials: _____ **Date:** _____

In addition to MD's, the following is a list of acceptable qualified professionals determined by HUD to diagnose a disability:

LMSW (Licensed Master Social Worker)	LCSW (Licensed Clinical Social Worker)	LPHP (Licensed Practitioner Health Professional)
LNP (Licensed Nurse Practitioner)	LCDC (Licensed Chemical Dependency)	LPC (Licensed Professional Counselor)
LMFT (Licensed Marriage Family Therapy)	PhD (Licensed Psychologist)	

If not able to sign, please explain: _____

_____

Signature/Credentials: _____ **Date:** _____

APPLICANT'S AUTHORIZATION TO RELEASE INFORMATION

I, _____, hereby authorize the release of the requested information pertaining to my disability to the Agency named above.

_____ _____

Applicant's Signature Date