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| **PART 1: INSTRUCTIONS** |
| * To be eligible for all CoC funded PSH, evidence that one or more members of the household is diagnosed with a disability must be documented in the participant file.
* To be eligible for a PSH unit that is dedicated to serve chronically homeless people, the disability must be documented for an adult head of household, or, if there is no adult in the family, a minor head of household.
* This form can also be used for CoC-fundd TH or other programs that have committed to serving disabled people.
* Complete all fields in Part 2.
* Complete all fields under the relevant option in Part 3
* Attach all supporting documents to this form.

 * Maintain this form and all supporting documents in the participant’s file.
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| **PART 2: GENERAL INFORMATION** |
| **Admitting Agency Name:** | **Program Name:** |
|  |  |
| **Participant Name:** | **HMIS #** | **Date of Birth** | **Date of Intake** |
|  |  |  |  |
| **Part 3: DISABILITY CERTIFICATION** |
| **Option #1: Social Security (SSI/DI) or Veteran’s Disability** |
| Evidence must include one of the following (Check One): A) Written verification from the Social Security Administration; OR B) Copies of a disability check (e.g., SSI, SSDI or Veterans Disability Compensation) |
| **ATTACH EVIDENCE OF EITHER A OR B TO THIS FORM**  Check here to indicate that evidence  has been attached. |

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| **Option #2: Verification by a Licensed Professional** |
| I, hereby, certify that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Insert Participant Name) has been diagnosed with at least one of the following:* A physical, mental, or emotional impairment, including an impairment caused by alcohol or drug abuse, post-traumatic stress disorder, or brain injury that: Is expected to be long-continuing or of indefinite duration; and substantially impedes the individual's ability to live independently; and could be improved by the provision of more suitable housing conditions; OR
* A developmental disability, as defined in section 102 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15002); OR
* The disease of acquired immunodeficiency syndrome (AIDS) or any condition arising from the etiologic agency for acquired immunodeficiency syndrome (HIV).
 |
|  Check here to indicate that additional information regarding diagnosis has been attached (optional).  |
| Notes (optional):  |
| **Information About the Certifying Licensed Professional** |
| Signature of Licensed Professional:  | Credentials: | Date: |
| Printed Name:  | Organization: |
| License #: | Phone #: |
| **Option #3: Intake or referral staff observation****Must be confirmed within 45 days of the application for assistance by evidence from Option #1 or #2 above.** |
| I hereby certify that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Insert Participant Name) meets the HUD definition of disability. |
| Signature of Staff: | Title: | Date: |
| Printed Name:  | Organization: |