DCA/GHFA Prescribed - HUD McKinney Program - Disability Verification Form

DCA/GHFA Grantee or Sponsoring Agency: _____

Head of Household: _____ SS#: _____ DOB: _____

Verification Requested
For Adult Household Member: _____ SS#: _____ DOB: _____

The person identified above is applying for Shelter Plus Care Assistance. We are required by HUD to verify information provided by the family. The applicant has claimed that the family member indicated above is disabled. To verify this status, please complete this form and return it to the Sponsor named below.

Check one of the 3 boxes below:

1. ☐ The person is disabled and is on SSI (current SSA award letter attached).

2. ☐ The person has a physical, mental, or emotional impairment that is expected to be of long-continued and indefinite duration; substantially impedes his or her ability to live independently; and is of such a nature that ability to live independently could be improved by more suitable housing conditions.

3. ☐ The person has a developmental disability, which is a severe, chronic disability that-- (i) Is attributable to a mental or physical impairment or combination of mental and physical impairments; (ii) Manifested before the person attained age 22; (iii) Is likely to continue indefinitely; (iv) Results in substantial functional limitations 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 which are of lifelong or extended duration and are individually planned and coordinated.

Complete the following information:

1. Describe disability(ies) - attach additional pages, if necessary:

_____

_____

_____

_____

2. Does this person need a live-in aide to provide supportive services essential to his/her care and well being?
☐ **Yes** ☐ **No** If yes, explain

_____

_____

IN MY PROFESSIONAL OPINION, I CERTIFY THAT THE INFORMATION LISTED ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

Type or Print Name of Professional:

_____

Signature of Licensed Certifying Professional:

_____

Date:

_____

Qualification:

☐ Licensed Clinical Social Worker ☐ Psychiatrist
☐ Clinical Nurse Specialist
☐ Physician ☐ Psychologist

License number:

_____

THIS FORM IS INVALID WITHOUT APPLICABLE LICENSE NUMBER

Last Modified: February 15, 2016