VERIFICATION OF DISABILITY FOR ORANGE COUNTY, CA AREA

☐ SERVICE PROVIDER_____	**HOUSING AUTHORITY USE ONLY:**
ADDRESS_____	PHA DESIGNATED HEAD OF HOUSEHOLD:
EMAIL_____	_____
PHONE_____ FAX _____	TENANT ID_____
CONTACT_____	☐AHA ☐GGHA ☐OCHA ☐SAHA

The patient below is applying for housing assistance under a program of the U.S. Department of Housing and Urban Development (HUD). HUD regulation require verification of information related to program eligibility. To comply with this requirement, we ask for your cooperation in completing and returning this verification form within 10 business days by fax, mail, or e-mail to the entity indicated above. Questions about the form may be directed to the person named as the contact above. Thank you for your assistance in this matter.

Patient Name: _____ SS (last 4)#: _____ Date of Birth: _____

Address: _____

Patient Signature: _____ Date: _____

TO BE COMPLETED BY KNOWLEDGEABLE PROFESSIONAL

DISABILITY: (PLEASE CHECK ONE)
Regulation: 24 CFR 5-403 defines HUD's criteria for persons who are considered disabled if they have a disability as defined in Section 223 [42 U.S.C. 423]:

☐ "Inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted **or** can be expected to last for a continuous period of not less than 12 months; **or** in the case of an individual who has attained the age of 55 and is blind (within the meaning of "blindness" as defined in section 216(i)(1)), inability by reason of such blindness to engage in substantial gainful activity requiring skills of abilities comparable to those of any gainful activity in which he has previously engaged with some regularity and over a substantial period of time." **Or** has a developmental disability as defined in [42 U.S.C. 6001].

☐ **Developmental Disability**: is defined as a disability that is attributable to any of the following conditions: Intellectual disability, Cerebral palsy, Epilepsy, Autism, or disabling conditions found to be closely related to intellectual/cognitive disability or to require treatment similar to that required for individuals with intellectual disabilities. The disability must have originated before the age of eighteen (18) and can be expected to continue indefinitely, and constitute as a "substantial disability" for the individual as defined by Title 17, Section 54001 of the California Code of Regulations. Additional details regarding how a substantial disability is defined can be found in ARCA's Clinical Recommendations for Defining Substantial Disability.

(PLEASE CHECK ONE)
I hereby certify that according to this definition, the individual names above is ☐ disabled ☐ not disabled.

Warning: It is unlawful to "knowingly and willfully" make any "materially false, fictitious, or fraudulent statements or representation" to a federal agency. Violations can be punished under Section 2 of the False Statements Act by a fine and/or imprisonment of not more than 5 years. [18 U.S.C. § 1001]

I declare, under penalty of perjury under the laws of the United States of America and the State of California, that the information above is true, correct, and complete.

Printed Name _____ Title _____ Date _____

Signature of Knowledgeable Professional _____ Phone _____ License Number _____

Organization Name _____ Address _____ City/State _____ Zip Code _____

Internal Use Only: ☐ Annual: _____ ☐ Interim ☐ Initial

Disabling Condition Verification Form

Patient Name		**Date of Birth**	

I verify, as the undersigned, that the individual named above has been diagnosed, or I have diagnosed with one of the following conditions:

☐ Substance use disorder
☐ Serious Mental Illness
☐ Developmental Disability (As defined by 42 U.S.C. 15002)
☐ Post-Traumatic Stress Disorder
☐ Cognitive impairments resulting from brain injury
☐ Chronic physical illness or disability

That the above condition is expected to be of long-continued or indefinite duration: ☐Yes ☐No

That the above condition impedes the individuals' ability to live independently: ☐Yes ☐No

That the individual's ability to live independently will be improved by a more suitable housing condition: ☐Yes ☐No

Verification must be provided by a state licensed qualified source that may include medical service providers, Licensed Marriage and Family Therapist (LMFT), Licensed Clinical Social Worker (LCSW), physicians or treating health care provider as stated in the Social Security Act – 42 U.S.C. Section 423.

Name		**License #**	
Title		**Organization/ Firm**	
Address		**Phone #**	
Signature		**Date**	

COUNTY OF ORANGE CALIFORNIA

coordinated ENTRY SYSTEM