CERTIFICATION OF DISABILITY

Date: _____

I, _____, authorize release of the information below.
Applicant Name

_____
Applicant Signture

Dear Physician/Qualified Health Personnel: _____
Applicant Name

has claimed eligibility for a federally funded housing program due to a disabling chronic condition. The claim must be certified by a licensed physician or qualified health professional. For the purpose of this program, a disabled person is an individual with a physical, developmental or mental impairment that substantially limits one or more major life activities. Such impairments include, but are not limited to, such diseases and conditions as serious mental illness, orthopedic, visual, speech and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, developmental disability, HIV/AIDS (whether symptomatic or asymptomatic), tuberculosis, drug addiction, and alcoholism.

This disability must be expected to be of a long-continued and indefinite duration, substantially impede independent living, and is of such a nature that daily functioning and the disability could improve under more suitable housing conditions. Please provide the information requested below.

Requested by: _____ at: _____.
Agency Employee Name — Agency Contact Information

(Section to be completed by certifying Health Professional only.)

MEDICAL CERTIFICATION

In my opinion, as a licensed physician/qualified health professional trained to evaluate such conditions, _____ ***does not*** have a disability as defined above.
Applicant's Name

or

In my opinion, as a licensed physician/qualified health professional trained to evaluate such conditions, _____ ***does*** have a disability as defined above.
Applicant's Name

Additional information concerning this disability:
This disability:

Is expected to be of long-continued and indefinite duration. ☐ Yes ☐ No

Substantially impairs his/her ability to live independently. ☐ Yes ☐ No

Is of such nature that daily functioning and the disability could improve under more suitable housing conditions. ☐ Yes ☐ No

This disability is:
- ☐ Chronic Physical Illness or Disability
- ☐ Serious Mental Illness
- ☐ Developmental Disability
- ☐ AIDS or HIV Related Diseases
- ☐ Diagnosable Substance Abuse Disorder
- ☐ Co-occurrence of Two or More of these Conditions

Signature: _____ **Print Name:** _____

Professional Title: _____ **Telephone:** _____

License Number: _____ **Date:** _____

Name of Medical Group (stamp preferred): _____

Address: _____

Email: _____

Organization Stamp: