Gulf Coast Partnership
Together We Can
One Charlotte

VERIFICATION OF DISABILITY FORM

The following individual, _____, is determined to be eligible for participation in your HUD program, as they are considered to be disabled. *(A person shall be considered to have a disability if such person has a physical, mental, or emotional impairment, which 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 such ability, could be improved by more suitable housing conditions.)*

- A person will also be considered to have a disability if he or she has a developmental disability, which is a severe, chronic disability that:
  - ☐ Is attributable to a mental or physical impairment or combination of mental and physical impairments
  - ☐ Is manifested before the person attains age 22
  - ☐ Is likely to continue indefinitely
  - ☐ Results in substantial functional limitations in three or more of the following areas of major life activity:
    - Self-care
    - Receptive and expressive language
    - Learning
    - Mobility
    - Self-direction
    - Capacity for independent living
    - Economic self-sufficiency
  - ☐ 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.
- Federal laws define a person with a disability as "Any person who has a physical or mental impairment that substantially limits one or more major life activities; has a record of such impairment; or is regarded as having such an impairment." In general, a physical or mental impairment includes hearing, mobility and visual impairments, chronic alcoholism, chronic mental illness, AIDS, AIDS Related Complex, and mental retardation that substantially limits one or more major life activities. Major life activities include walking, talking, hearing, seeing, breathing, learning, performing manual tasks, and caring for oneself.

I have reviewed this definition and determined that:

_____, meets the above disability criteria.

[Disability may also include those with a chemical dependency disability as a primary diagnosis.]

Signature: _____ Date: _____

Name (printed) _____

Professional Title _____ License or Certification ID#: _____

Organization/Agency Name: _____ Telephone (____)_____

(Documentation of a disability **MUST come from a credentialed and licensed psychiatrist or medical professional trained to make such a determination or from the Social Security Administration). It is suggested that the diagnosis be included for an agency to make a reasonable assessment of needs. **Please attach a statement or an assessment attesting to the current condition (consistent with the Type of Disability checked above) of the applicant to this program**. Please be as specific as possible documenting the limiting factors of the condition (i.e. functional deficits)*