CoC Program Participant
Disability Verification Form

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.

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:	