

LONG BEACH COORDINATED ENTRY
VERIFICATION OF DISABILITY

Date: _____

To:

Dear _____,

_____ (*Head of Household's Name*) is applying for a supportive housing program as defined by the U.S. Department of Housing and Urban Development (HUD). The attached Verification of Disability form is part of the eligibility process. We are requesting your assistance in completing and returning this form as quickly as possible to:

_____ *Referring/Verifying Agency*

_____ *Contact Person*

_____ *Phone and Fax*

_____ *Address*

_____ *Email*

Please contact us with any questions or concerns.

Sincerely,

_____ *Signature of Agency Representative*

Client Consent for Release

I hereby authorize the release of the information requested in the attached *Verification of Disability* form for the purpose of verifying my eligibility for supportive housing and related services.

_____ *Signature of Head of Household*

_____ *Date**

OR

I certify that the applicant provided oral consent for the release of the information requested in the attached Verification of Disability form for the purpose of verifying their eligibility for supportive housing and related services.

_____ *Signature of Agency Representative*

_____ *Date**

*This release of information will expire one year from the date of the applicant's written or oral consent indicated above.

(ONLY a licensed professional with credentials to diagnose an individual and treat that diagnosis may complete this form)

_____ (Household's Name) is applying for a supportive housing program as defined by the U.S. Department of Housing and Urban Development (HUD). This form is part of the eligibility process; please call us with any questions or concerns. We are requesting your assistance in completing and returning this form as quickly as possible to:

_____ *Referring/Verifying Agency*

_____ *Address*

_____ *Contact Person*

_____ *Email*

_____ *Phone and Fax*

Eligibility Disability Types

Please select all of the following that apply:

- a disability as defined in Section 223(d) of the Social Security Act as the "inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which...has lasted or can be expected to last for a continuous period of no less than 12 months..."
- a physical, mental, or emotional impairment which is (a) expected to be of long-term, continued, and indefinite duration, (b) substantially impedes an individual's ability to live independently, and (c) of such a nature that such ability could be improved by more suitable housing conditions;
- a developmental disability as defined in Section 102(8a) of the Developmental Disabilities Assistance and Bill of Rights Act. In general, this "...means a severe, chronic disability of an individual that - is attributed to a mental or physical impairment of combination of mental and physical impairments"
- the disease of acquired immunodeficiency syndrome (AIDS) or any condition arising from the etiological agency for acquired immunodeficiency syndrome (HIV)

Disability Information

Please check all that apply:

- Mental Health Disorder
- Substance Use disorder
- Co-occurring Mental Health Disorder and Substance Use Disorder
- HIV/AIDS
- Physical Disability
- Developmental Disability

Please check appropriate credential:

(ONLY a licensed professional with credentials to diagnose an individual and treat that diagnosis may complete this form)

- | | | |
|---|---|--------------------------------|
| <input type="checkbox"/> Licensed Clinical Social Worker | <input type="checkbox"/> Nurse Practitioner | <input type="checkbox"/> Other |
| <input type="checkbox"/> Licensed Clinical Professional Counselor | <input type="checkbox"/> Psychiatrist | (please specify): |
| <input type="checkbox"/> Physician | <input type="checkbox"/> Psychologist | |
| <input type="checkbox"/> Physician's Assistant | <input type="checkbox"/> Certified Nurse Practitioner | |

_____ *Signature*

_____ *Printed Name*

_____ *License Number*

_____ *Date*

_____ *Office/Practice/Agency Name*

_____ *Phone Number*

