VERIFICATION OF DISABILITY FORM

INSTRUCTIONS: A qualified professional must complete this form. Please check box in front of Section 1 or Section 2 as applicable, and answer "yes" or "no" in that section. Section 3 complete for all. (Qualified professional is a person licensed to diagnose a particular medical condition such as a MD, DO, LCPC, LCSW, APRN-BC, FNP, NP.)

NAME: _____ DOB: _____

☐ **SECTION 1: APPLIES TO PERSONS WITH A PHYSICAL, PSYCHIATRIC, CHRONIC SUBSTANCE ABUSE, HIV-AIDS or CONDITION/IMPAIRMENT OTHER THAN A DEVELOPMENTAL DISABILITY.**

The above named person is an adult (18 or older) who:

(a) has a condition/impairment which has lasted or is expected to last for a long (1 year or more), continuous and indefinite period of time; ☐ **YES** ☐ **NO**

(b) has a condition/impairment which impacts the person's ability to live independently (needs some type of assistance to carry out normal daily living tasks or limits ability to be economically self-sufficient); ☐ YES ☐ NO

(c) having a more suitable/stable housing conditions might improve the person's situation. ☐ YES ☐ NO

If "Yes" is checked for a, b, and c above please check "Yes"; if not please check "No". ☐ YES ☐ NO

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☐ **SECTION 2: APPLIES TO PERSONS WITH A DEVELOPMENTAL DISABILITY**

The above named person is an adult with a chronic and severe developmental disability which:

(a) is a mental and/or physical impairment or combination mental/physical impairment; ☐ YES ☐ NO

(b) was manifested before the person attained age 22; ☐ YES ☐ NO

(c) is likely to continue indefinitely; ☐ YES ☐ NO

(d) results in substantial functional limitations in three (3) or more of the following areas of major life activity: self-care; receptive and expressive language; learning; mobility; self-direction; capacity for independent living; and economic self-sufficiency; ☐ YES ☐ NO

(e) reflects a need for a combination of special interdisciplinary or generic care, treatment, or other services which are of lifelong, or extended duration and are individually planned and coordinated; ☐ YES ☐ NO

(f) the person's situation could be improved by more suitable housing conditions. ☐ YES ☐ NO

If "Yes" is checked for a, b, c, d, e and f above please check "Yes", otherwise check "No'". ☐ YES ☐ NO

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SECTION 3: COMPLETE FOR ALL PERSONS

The individual named above is an individual with one or more of the following. (Check all that apply.)

☐ Psychiatric/Emotional Disability Onset date: _____

☐ Chronic Alcohol Abuse Onset date: _____

☐ HIV/AIDS Onset date: _____

☐ Chronic Substance Abuse Onset date: _____

☐ Physical Disability Onset date: _____

☐ Other Disability _____ Onset date: _____

_____ _____

Name of Person Completing Form **Provider Telephone Number**

_____ _____

Signature **Date**