

**DISABILITY/HANDICAPPED STATUS VERIFICATION**

Applicant's Name

Social Security #

Address

City

State

Zip Code

TO: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

FROM \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PLEASE RETURN THIS FORM TO THE  
PERSON LISTED HERE

Thank you for your cooperation. All information is confidential. If you have any questions, please contact: \_\_\_\_\_  
at ( ) \_\_\_\_\_.

PERMISSION FOR RELEASE OF INFORMATION

**YOU DO NOT HAVE TO SIGN THIS FORM IF EITHER THE REQUESTING ORGANIZATION OR THE ORGANIZATION SUPPLYING THE INFORMATION IS LEFT BLANK.**

RELEASE: I hereby authorize the release of the requested information. Information obtained under this consent is limited to information that is no older than 12 months. There are circumstances which would require the owner to verify information that is up to 5 years old, which would be authorized by me on a separate consent attached to a copy of this consent.

Signature

Date

**To the Applicant's/Tenant's Medical Doctor:**

Please review the definitions below and indicate whether or not the applicant is disabled as defined in Section 223 of the Social Security Act, or Section 102 (b)(5) of the Developmental Disabilities Services and Facilities Construction Amendment of 1970, or as defined in 24 CFR Section 5.403.

- A. Inability to engage in any substantial, gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. Yes  No
- B. In the case of an individual who has attained an age of 55 and is blind (within the meaning of "blindness" as defined in Section 416 (i) (1): inability by reason of such blindness to engage in substantial gainful activity in which he/she has previously engaged with some regularity and over a substantial period of time. Yes  No
- C. A disability attributable to mental retardation, cerebral palsy, epilepsy, or another neurological condition of an individual found by the Secretary (of Health, Education, and Welfare) to be closely related to mental retardation or to require treatment similar to that required for mentally retarded individuals, which disability originates before such individual attains age twenty-two, which has continued or can be expected to continue indefinitely, and which constitutes a substantial handicap to such individual. Yes  No
- D. A handicapped person as defined in 24 CFR Section 5.403: a person having a physical or mental impairment which (1) is expected to be of long-continued and indefinite duration, (2) substantially impedes his/her ability to live independently, **and** (3) is of such nature that such a disability could be improved by more suitable housing conditions. Yes  No

If you are unable to complete this form, please indicate reason: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**I certify that this form is completed in response to a direct and explicit request of the patient.**

\_\_\_\_\_  
Doctor's Name (Print or type)

\_\_\_\_\_  
Signature of Doctor

(\_\_\_\_\_) \_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Date

\_\_\_\_\_  
**Warning: Section 1001 of Title 18 of the U. S. Code makes it a criminal offense to make willful false statements or misrepresentations to any Department or Agency of the United States as to any matter within its jurisdiction.**  
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