HOUSING DISABILITY VERIFICATION FORM
TO BE COMPLETED BY A QUALIFIED HEALTH CARE PROFESSIONAL

Date Form Completed: _____

This disability verification form is for:

Client/Patient Name: _____

Client/Patient Date of Birth: _____

Clinician Contact Information:

Organization Name (if applicable): _____

Address: _____

Phone #: _____

E-mail: _____

I am a credentialed and licensed health care professional trained to perform diagnostic and functional assessments of clients/patients. Within my scope of practice, I have determined that the client named above has the following diagnosable conditions (check ALL that apply):

- ☐ Substance use disorder
- ☐ Serious mental illness (as defined in the DSM and is severe in degree and persistent in duration; is NOT a substance use disorder, development disorder, or acquired traumatic brain injury)
- ☐ Developmental disability (as defined in Section 102 of the Development Disabilities Assistance Bill of Rights Act of 2000, {42 U.S.C. 15002}),
- ☐ Cognitive impairments resulting from brain injury
- ☐ Chronic physical illness or disability
- ☐ HIV infection or AIDS

According to my assessment, one or more of these conditions is expected to be of long-continued and indefinite duration. One or more of these conditions substantially impedes the aforementioned individual's ability to live independently. One or more of these conditions is of such a nature that the client's ability to live independently could be improved by more suitable housing conditions. My signature below indicates my verification of the above information for this client.

Signed _____ Date_____

Name (printed) _____

Professional License Type: _____ License #: _____