Medical Statement of Certification of Disability

(To be completed by a licensed medical provider)

This form is not to be used to determine disability for Social Security benefits. It is only to provide documentation for housing programs.

Applicant's Name_____ SSN_____

Address_____

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 that 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.

Authorization to release medical information by:_____ Date_____

The above named person is applying for participation or is a current participant in our housing program. To determine the applicant's/participant's eligibility and/or level of subsidy, this program must verify the disability as defined by the U.S. Department of Housing and Urban Development (HUD). HUD regulations define disability as follows:

1. A person who has a physical, mental, or emotional impairment, including an impairment caused by alcohol or drug abuse, post-traumatic stress disorder, or brain injury, which:
    a. is expected to be of long-continued and indefinite duration;
    b. substantially impedes his/her ability to live independently; and
    c. is of such a nature that such ability could be improved with more suitable housing conditions.
2. A person who has a developmental disability that:
    a. is attributable to a mental or physical impairment or combination of mental and physical impairment;
    b. is manifested before the person attains the age of 22;
    c. is likely to continue indefinitely;
    d. results in substantial functional limitation in three (3) or more of the following areas of major life activity:
        (1) self-care,
        (2) receptive and responsive language,
        (3) learning,
        (4) mobility,
        (5) self-direction,
        (6) capacity for independent living, and
        (7) economic self-sufficiency; and
    e. reflects the person's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated
3. A person who has Acquired Immunodeficiency Syndrome (AIDS) or any conditions arising from the etiologic agent for Acquired Immunodeficiency Syndrome, including infection with the Human Immunodeficiency Virus (HIV).

If the foregoing accurately establishes the medical status of the applicant/participant as having a disability defined above, please indicate your approval by signing this document and returning both pages of the document to:

_____

_____.

Created by the WI BOS CoC Centralized & Coordinated Assessment Committee 10/16/13
Approved by the WI Balance of State Board of Directors 10/17/2013

HUD regulations require that this certification of disability be completed and signed by a professional licensed by the state to diagnose and treat the disability and his/her certification that the disability is expected to be long-continuing or of indefinite duration and substantially impedes the individual's ability to live independently.

Certification of Disability

The applicant/participant ☐ does ☐ does not have a disability according to HUD definitions.

Applicable definition (s) ☐ 1 ☐ 2 ☐ 3

Please print name of licensed medical provider

Signature of licensed medical provider

Address

Date

Business telephone number

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