HOME FOR GOOD
Santa Barbara County

VERIFICATION OF DISABILITY

From (Staff Submitting Form):_____

Agency Address:_____

_____

Dear:_____

Your Patient:_____DOB:_____SSN:_____ is requesting housing assistance through a federally funded housing program. In compliance with federal HUD regulations, we are required to verify income and other related eligibility criteria. This verification is for the confidential use of Northern Santa Barbara County United Way/Santa Barbara County Home For Good Coordinated Entry System for purpose of initial and on-going eligibility determinations only. If you have any questions regarding this matter, please contact our office at: (805) 922-0329

I HEREBY GIVE MY CONSENT FOR RELEASE OF THE REQUESTED INFORMATION

CLIENT'S SIGNATURE: _____ DATE: _____

Section 401 (9) of the McKinney-Vento Homeless Assistance Act defines "homeless individual with a disability" as an individual who is homeless and has a disability that:

(i) (I) is expected to be long-continuing or of indefinite duration;
(II) substantially impedes the individual's ability to live independently;
(III) could be improved by the provision of more suitable housing conditions; and
(IV) is a physical, mental, or emotional impairment, including an impairment caused by alcohol or drug abuse, post traumatic stress disorder, or brain injury;

(ii) is a developmental disability, as defined in section 102 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15002); or

(iii) is the disease of acquired immunodeficiency syndrome or any condition arising from the etiologic agency for acquired immunodeficiency syndrome.

1. Does this individual have a disability, as defined above? Yes _____ No _____

2. The person signing the form has personally evaluated or treated the patient Yes _____ No _____

3. The person signing the form is a: ❏ Doctor ❏ Psychiatrist ❏ Psychologist ❏ Nurse Practitioner ❏ Physician Assistant ❏ Licensed Clinical Social Worker (LCSW) ❏ Licensed Professional Clinical Counselor (LPCC) ❏ Licensed Marriage and Family Therapist (LMFT) ❏ Licensed Educational Psychologist (LEP) ❏ Addiction counselors with certificates from CAADE, CADTP, or CCAPP ❏ Other:_____

_____ _____
EVALUATOR/DIAGNOSTICIAN NAME (PRINT) **EVALUATOR/DIAGNOSTICIAN SIGNATURE**

_____
EVALUATOR/DIAGNOSTICIAN JOB TITLE

_____ _____
TELEPHONE NUMBER **DATE**