CoC Program Participant
Disabling Condition Verification Form

PART 1: INSTRUCTIONS
• To be eligible for all CoC funded PSH, evidence that one or more members of the household is diagnosed with a disabling condition must be documented in the participant file. • To be eligible for a PSH unit that is dedicated to serve chronically homeless people, the disabling condition must be documented for an adult head of household, or, if there is no adult in the family, a minor head of household. • This form can also be used for CoC-funded TH or other programs that have committed to serving disabled people. • Complete all fields in Part 2. • Complete all fields under the relevant option in Part 3 • Attach all supporting documents to this form. (NOTE: This form does not require specifying disability.) • Maintain this form and all supporting documents in the participant's file.

PART 2: GENERAL INFORMATION			
Admitting CoC Agency Name:	**CoC Project Name:**		
Contact Person Name:			
Contact Person Phone:	**Contact Person Email:**		
Participant Name:	**HMIS #**	**Date of Birth**	**CoC Project Entry Date**

Part 3: DISABLING CONDITION CERTIFICATION
Option #1: Social Security (SSI/DI) or Veteran's Disability
Evidence must include one of the following (Check One): ☐ A) Written verification from the Social Security Administration; OR ☐ B) Copies of a disability check (e.g., SSI, SSDI or Veterans Disability Compensation)
ATTACH EVIDENCE OF EITHER A OR B TO THIS FORM ☐ Check here to indicate that evidence has been attached.

CoC Program Participant
Disabling Condition Verification Form

Option #2: Verification by a Qualified Licensed Professional
(Certifying professional must be licensed by the State to diagnose and treat the qualifying condition.)

I, hereby, certify that _____(Insert Participant Name) has been diagnosed with at least one of the following:

- A physical, mental, or emotional impairment, including an impairment caused by alcohol or drug abuse, post-traumatic stress disorder, or brain injury that: Is expected to be long-continuing or of indefinite duration; and substantially impedes the individual's ability to live independently; and could be improved by the provision of more suitable housing conditions; OR
- 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
- The disease of acquired immunodeficiency syndrome (AIDS) or any condition arising from the etiologic agency for acquired immunodeficiency syndrome (HIV).

I also, hereby, certify that I am licensed by the State of Connecticut to diagnose and treat the condition that I am certifying above.

☐ I hereby certify that the above named individual has been diagnosed with a DMHAS eligible disabling condition.

☐ Check here to indicate that additional information regarding diagnosis has been attached (optional). (NOTE: This form does not require specifying disability.)

Notes (optional):

Information About the Certifying Licensed Professional

Signature of Licensed Professional:	Credentials:	Date:
Printed Name:	Organization:	
License #:	Phone #:	

Option #3: Intake or referral staff observation
Must be confirmed within 45 days of the application for assistance by evidence from Option #1 or #2 above.

I hereby certify that _____ (Insert Participant Name) meets the HUD definition of disability. (NOTE: This form does not require specifying disability.)

Signature of Staff:	Title:	Date:
Printed Name:	Organization:	