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| **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 project designated to serve people who meet the HUD definition of [DedicatedPLUS](https://www.ctbos.org/wp-content/uploads/2020/12/Dedicated-Plus-CT-BOS-Webinar-2020.12.02-v3.pdf) homelessness, the disabling condition must be documented for an adult head of household, or, if there is no adult in the household, a minor head of household. * This form can also be used for other programs that have committed to serving people with a disability. * 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 a disability.) * Maintain this form and all supporting documents in the participant’s file and upload to HMIS. | | | |
| **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. | | | |

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| **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 use, 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 a 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 a disability.) | | | |
| Signature of Staff: | Title: | Date: | |
| Printed Name: | Organization: | | |