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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: |