

Disability Verification Form - HUD PSH
Verification by a Qualified Licensed Professional

Continuum of Care (CoC) FL-507

**Must be completed by a qualified professional who is licensed by the State to diagnose and treat the qualifying condition.*

I certify that _____ 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;*
 - *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).

For purposes of qualifying for supportive housing, does not include a person whose disability is based solely on drug or alcohol dependence.

I am diagnosing this participant with one or more of the following disabling conditions (check all that apply):

- Alcohol Use Disorder Drug Use Disorder Physical Developmental HIV/AIDS
 Chronic Health Condition Severe & Persistent Mental Illness Cognitive Impairments from Brain Injury

List the participant's diagnosed disability (*Corresponding ICD-codes recommended, as some programs require these*):

Licensed Professional's Printed Name

Medical Providers Street Address

Title/Credentials

City, St, Zip

License Number

Phone Number

Signature

Date