



DISABILITY VERIFICATION FORM

Revised August 2016



Date of Verification: _____

First Name: _____ Last Name: _____

Address: _____

For the purpose of this program, the applicant/tenant must meet the following criteria: a) As a result of her/his disability, the need for treatment is expected to be of a long, continued, and indefinite duration; b) The disability substantially impedes her/his ability to live independently; and c) The disability is of such nature that it could be improved by more suitable housing conditions. If the participant is disabled by chronic problems with alcohol and/or drugs, the problematic use must have occurred for at least 12 months and caused serious difficulties in interpersonal relationships as evidenced by disruptions in employment, loss of housing, and/or loss of role in family structures or other important relationships.

Primary Diagnosis:

- Mental Health
- HIV/AIDS
- Drug Abuse
- Alcohol Abuse
- Alcohol & Drug Abuse
- Chronic Health Condition
- Developmental Disability
- Physical
- Other (Please specify) _____

Secondary Diagnosis:

- Mental Health
- HIV/AIDS
- Drug Abuse
- Alcohol Abuse
- Alcohol & Drug Abuse
- Chronic Health Condition
- Developmental Disability
- Physical
- Other (Please specify) _____

Disability Status:

- Currently receiving SSI/SSDI
- NOT currently receiving SSI/SSDI

➔ Signature of Licensed Clinician _____ Date _____

Print Name of Person Signing Form _____ License Number _____

Title of Person Signing Form _____

HOUSING RESOURCE & DEVELOPMENT AGENCY

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TDD/TTY: 1-800-545-1833, ext. 873



A Contract Agency of the Alcohol, Drug and Mental Health Services Board of Cuyahoga County