DISABLING CONDITION VERIFICATION FORM

Patient Name	Date of Birth

I verify, as the undersigned, that the individual named above has been diagnosed, or I have diagnosed with one of the following conditions:

☐ Substance Use Disorder
☐ Serious Mental Illness
☐ Developmental Disability (As defined by 42 U.S.C. 15002)
☐ Post-Traumatic Stress Disorder
☐ Cognitive impairments resulting from brain injury
☐ Chronic physical illness or disability

That the above condition is expected to be of long-continued or indefinite duration: ☐ Yes ☐ No

That the above condition impedes the individuals' ability to live independently: ☐ Yes ☐ No

That the individual's ability to live independently will be improved by a more suitable housing condition: ☐ Yes ☐ No

Verification must be provided by a state licensed qualified source that may include medical service providers, Licensed Marriage and Family Therapist (LMFT), Licensed Clinical Social Worker (LCSW), physicians or treating heath care provider as stated in the Social Security Act – 42 U.S.C. Section 423.

Name _____ License # _____

Title _____ Organization/Firm _____

Address _____ Phone # _____

Signature _____ Date _____

Revised 06/09/23