Disability Verification Form

Date: ___________________________________

Agency Name: _____________________________________________________________________

Name of Client: ____________________________________________________________________

As a credentialed mental health or medical professional, it is my determination that the above-named client _______________ has been diagnosed with one or more of the following (check all that apply):

Categories below are mapped in alignment with current HMIS Barriers data entry response options in parentheses.
*HIV/AIDS is not specified in HUD’s clarification on Chronic Homeless Documentation Checklist but available in HMIS.

- [ ] Yes  [ ] No  Alcohol Abuse  (Substance Use Disorder)
- [ ] Yes  [ ] No  Drug Abuse  (Substance Use Disorder)
- [ ] Yes  [ ] No  Serious Mental Illness  (Mental Illness)
- [ ] Yes  [ ] No  Post-traumatic Stress Disorder  (Mental Illness)
- [ ] Yes  [ ] No  Developmental Disability
- [ ] Yes  [ ] No  HIV/AIDS*
- [ ] Yes  [ ] No  Cognitive Impairments Resulting from Brain Injury  (Physical Disability)
- [ ] Yes  [ ] No  Chronic Physical Illness or Disability  (Physical Disability)
- [ ] Yes  [ ] No  Chronic Physical Illness or Disability  (Chronic Health Condition)

I have also determined that at least one of the condition(s) cited above substantially impairs the client’s functioning in the following ways (check all that apply):

1. The condition(s) is of a long continued and indefinite duration  [ ] Yes  [ ] No
2. The client’s mental and/or emotional impairment impedes their ability to live independently  [ ] Yes  [ ] No
3. The client’s mental and/or emotional impairment will be improved by more suitable housing conditions  [ ] Yes  [ ] No

__________________________________________________________
Signature of Credentialed Mental Health or Medical Professional

__________________________________________________________
Printed Name of Credentialed Mental Health or Medical Professional

_______________________  __________________  ______________
Medical License Number   Date Issued (mm/dd/yyyy)  Expiration Date (mm/dd/yyyy)

Date Signed

Adopted at KS-502 CASS Workgroup June 13, 2017