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