HOUSING AUTHORITY of SOUTH BEND

Tel: 574-235-9346
Web: www.hasbonline.com
501 Alonzo Watson Drive
South Bend, IN 46601

VERIFICATION OF DISABILITY

Housing Choice Voucher Program

Applicant/Participant Name _____

Voucher Number _____

Requesting Household Member _____

This person has applied or is receiving housing assistance under a program of the US Department of Housing and Urban Development (HUD). HUD requires the housing agency to verify all information that is used in determining this person's eligibility or level of benefits.

We ask your cooperation in providing the following information and returning it to the person listed at the top of the page. Your prompt return of this information will help to ensure timely processing of the application for assistance. The applicant/participant has consented to the release of information as shown above.

INFORMATION BEING REQUESTED

For each numbered item below, mark an "X" in the applicable box that accurately describes the person listed above.

1. ____ YES ____ NO Has a physical, mental, or emotional impairment that is expected to be of long-continued and indefinite duration, substantially impedes his or her ability to live independently, and is of a nature that such ability could be improved by more suitable housing conditions.

2. ____ YES ____ NO Is a person with a developmental disability, as defined in Section 102(7) of the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C. 6001(8)), i.e., a person with a severe chronic disability that:
    a. Is attributable to a mental or physical impairment or combination of mental and physical impairments;
    b. Is manifested before the person attains age 22;
    c. Is likely to continue indefinitely;
    d. Results in substantial functional limitation in three or more of the following areas of major life activity;
        i. Self-care;
        ii. Receptive and expressive language,

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iii. Learning,
iv. Mobility,
v. Self-direction,
vi. Capacity for independent living, and
vii. Economic self-sufficiency; and

e. Reflects the person's need for a combination of sequence of special, interdisciplinary, or generic care, treatment, or other services that are lifelong or extended duration and are individually planned and coordinated.

3. ____ YES ____ NO Is a person with a chronic mental illness, i.e., he or she has a severe and persistent mental or emotional impairment that seriously limits his or her ability to live independently, and whose impairment could be improved by more suitable housing conditions.

4. ____ YES ____ NO Is a person whose sole impairment is alcoholism or drug addiction.

_____
Name and Title of Person Supplying Information (Please Print)

_____
Firm/Organization Name

_____
Firm/Organization Current Address, City, State & Zip Code

_____ _____
Telephone (Office) Email Address (Office)

_____
Signature and Title of Person Supplying Information