



**Southern New Jersey Continuum of Care
Verification of Disability**

Applicant: _____ DOB: _____ Last 4 SSN Digits: _____

The Applicant is seeking placement into a HUD/Continuum of Care-funded Permanent Supportive Housing Program. To be eligible, the Applicant must have documentation of a HUD-defined disability.

Please complete EITHER Option 1 OR Option 2.

OPTION 1: Verification by a Qualified State Licensed Professional	
This section must be completed by a professional licensed by the state to diagnose and treat the disability. Acceptable qualified sources include physicians, state licensed psychologists/psychiatrists/clinical social workers.	
Instructions: Please check parts A, B, and/or C, if they apply to the Applicant. Please do not attach any psychiatric evaluations.	
<input type="checkbox"/> A. I. The Applicant has a physical, mental, or emotional impairment which: <ol style="list-style-type: none"> 1. is expected to be of long continued and indefinite duration, 2. substantially impedes an individual's ability to live independently, and 3. is of a nature that could be improved by more suitable housing conditions. <p align="center">Note: All three conditions above must be met.</p> II. Additionally, please specify the nature of the Applicant's disability that meets all of the three conditions listed above (check all that apply): <input type="checkbox"/> Substance Use Disorder <input type="checkbox"/> Post-traumatic stress disorder <input type="checkbox"/> Cognitive impairments <input type="checkbox"/> Serious mental illness <input type="checkbox"/> Chronic physical illness or disability resulting from brain injury	
<input type="checkbox"/> B. The Applicant has a developmental disability as defined in Section 102 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000.	
<input type="checkbox"/> C. The Applicant has the disease of acquired immunodeficiency syndrome (AIDS) or conditions arising from the etiologic agency for acquired immunodeficiency syndrome (HIV).	
Completed by:	
Signature of Licensed Professional:	Date:
Printed Name:	Practice/Agency Name:
Professional Credentials (e.g. M.D., D.O.)	Address:
State License Number:	Telephone:
Option 2: Receipt of SSI/DI or VA Disability Benefits	
Instructions: Receipt of SSI/DI or VA Disability Benefits must be documented using ONE of the following methods. Check the type of documentation used AND attach a copy of the documentation.	
<input type="checkbox"/> Written Verification from the Social Security Administration or the U.S. Department of Veterans Affairs <input type="checkbox"/> Copy of a disability check (e.g., SSI, SSDI, Veterans Disability Compensation)	
Agency Staff Member who Completed this Section:	
Name: Date:	
Title: Signature:	
Organization: Email:	