



Affordable housing as a platform to enhance lives.

# Verification of Disability HOUSING CHOICE VOUCHER PROGRAM

246 Sycamore Street, Suite 260, Decatur, GA 30030 • p 404.270.2500 f 404.270.2643

www.dekalbhousing.org

Applicant/Participant Name \_\_\_\_\_

Tenant ID \_\_\_\_\_

Requesting Household Member \_\_\_\_\_

This person has applied for housing assistance under a program of the U.S. 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/tenant has consented to this release of information as shown above.

### INFORMATION BEING REQUESTED

For each numbered item below, mark an "X" or "✓" 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;
    - (1) Self-care,
    - (2) Receptive and expressive language,
    - (3) Learning,
    - (4) Mobility,
    - (5) Self-direction,
    - (6) Capacity for independent living, and
    - (7) Economic self-sufficiency; and



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e. Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are of 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 Number (Office)

\_\_\_\_\_  
Telephone Number (Fax)

\_\_\_\_\_  
Email Address (Office)

\_\_\_\_\_  
Signature of Name and Title of Person Supplying Information

Do Not Write In This Space for Official HADC Use Only

Date Verification of 1<sup>st</sup> Attempt: \_\_\_\_\_ Verified: \_\_\_\_\_

Date Verification of 2<sup>nd</sup> Attempt: \_\_\_\_\_ Verified: \_\_\_\_\_

Date Verification of 3<sup>rd</sup> Attempt: \_\_\_\_\_ Verified: \_\_\_\_\_

Request Approved: \_\_\_\_\_

Request Denied: \_\_\_\_\_

Date Request Forwarded to Specialist: \_\_\_\_\_