TEL: 404-270-2500
FAX: 404-270-2550
HOUSING CHOICE VOUCHER FAX:
404-270-2643
www.dekalbhousing.org

750 Commerce Drive
Suite 201
Decatur, Georgia 30030

VERIFICATION OF DISABILITY

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 1st Attempt:___________ Verified: ____________
Date Verification of 2nd Attempt:___________ Verified: ____________
Date Verification of 3rd Attempt:___________ Verified: ____________

Request Approved:_____________
Request Denied: ______________

Date Request Forwarded to Specialist: ________________