Memphis/Shelby County Continuum of Care
Verification of Disability for Permanent Supportive Housing

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.

This verification 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.

Client Name:	**Client DOB:**
Client Release: I hereby authorize the release of the information requested below to the Memphis/Shelby County Continuum of Care for the purpose of determining my eligibility for a Permanent Supportive Housing Program.	
Client Signature:	Date:

Verification of Disability (VOD)	
Check One or More:	Instructions: Please check parts A, B, and/or C, if they apply to the Client. Please do not attach any psychiatric evaluations or other medical records.
[ ] A.	**The Client has a physical, mental, or emotional impairment** which: 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; **Note: All three conditions above must be met.** **Additionally**, please specify the nature of the Client's disability that meets all of the three conditions listed above (check all that apply): [ ] Substance use disorder [ ] Post-traumatic stress disorder [ ] Cognitive impairments resulting from brain injury [ ] Serious mental illness [ ] Chronic physical illness or disability **Additional Information:**
[ ] B.	The Client has a developmental disability as defined in Section 102 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000.
[ ] 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:	
Printed Name of Licensed Professional:	Practice/Agency Name:
Professional Credentials:	Telephone:
Signature of Licensed Professional:	Date:

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