

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>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.</i>	
Client Signature:	Date:

Verification of Disability (VOD)

Check 1 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.
<input type="checkbox"/> A.	<p>The Client has a physical, mental, or emotional impairment which:</p> <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>Note: All three conditions above must be met.</p> <p>Additionally, please specify the nature of the Client's disability that meets all of the three conditions listed above (check all that apply):</p> <p><input type="checkbox"/> Substance use disorder</p> <p><input type="checkbox"/> Post-traumatic stress disorder</p> <p><input type="checkbox"/> Cognitive impairments resulting from brain injury</p> <p><input type="checkbox"/> Serious mental illness</p> <p><input type="checkbox"/> Chronic physical illness or disability</p> <p>Additional Information:</p>
<input type="checkbox"/> B.	The Client 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:	
Printed Name of Licensed Professional: Practice/Agency Name:	
Professional Credentials:	Telephone:
Signature of Licensed Professional:	Date: