VERIFICATION OF DISABILITY - LICENSED PRESCRIBER STATEMENT

Applicant Name _____

Date of Birth _____

The client named above is applying for housing through the Indianapolis Continuum of Care. The criteria for inclusion in this program is that the person has a disabling condition.

Per HUD, the disabling condition must meet the following three criteria. Please mark which criteria are met.

- ☐ The disabling condition is expected to be of long-continued and indefinite duration
- ☐ The disabling condition substantially impedes an individual's ability to live independently
- ☐ The disabling condition is such that ability could be improved by more suitable housing conditions

Please indicate the following about this person's disabling condition:

☐ This individual has a condition that limits the individual's ability to work

Please explain:

☐ This individual has a condition that limits the individual's ability to perform at least three or more activities of daily living. **Please check those activities of daily living. Limitations must be explained.**

- ☐ Self care: _____
- ☐ Receptive and expressive language: _____
- ☐ Learning: _____
- ☐ Mobility: _____
- ☐ Self-direction: _____
- ☐ Capacity for independent living (functional assessment needed): _____
- ☐ Economic self-sufficiency: _____

Additional criteria includes that the individual has a diagnosis of SMI, addiction, and/or HIV+. Please indicate below how this individual meets the criteria and include diagnosis.

- ☐ Diagnosis of serious mental illness. List diagnosis: _____
- ☐ Diagnosis of addiction. List diagnosis: _____
- ☐ Diagnosis of HIV (additional verification needed for some housing programs)
- ☐ Diagnosis of medical/physical condition. List diagnosis: _____

_____
Licensed prescriber written name and credentials

_____ _____
Licensed prescriber signature Date

Note: form must be signed by credentialed, licensed person who can diagnose without confirming signature.

EQUAL HOUSING OPPORTUNITY