**Logo

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Coordinated Entry System

Verification of Disability

A copy of a recent Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) award letter or other written disability verification from the Social Security Administration can be accepted in lieu of this form. Additionally, this verification can be provided on the health provider’s letterhead if all required information is included.

**Service Provider Information (Person Requesting the verification on behalf of client)**

|  |  |
| --- | --- |
| Name |  |
| Agency |  |
| Phone |  |
| Fax |  |
| Address |  |

**Client Information**

|  |  |
| --- | --- |
| Name: |  |
| Date of Birth |  |

**Client Authorization**

I hereby authorize the release of the requested information to the Service Provider listed above, whether my disability is covered by the definitions below. This information may be used to verify my eligibility or to enable me to receive accommodations with certain housing programs.

|  |  |
| --- | --- |
| Client Signature |  |
| Date |  |

***Note to Client: You do not have to sign this form if either the requesting organization or the***

***organization supplying the information is left blank***

**Verification of Disability**

Does this person meet the definition of disability for homeless assistance programs? ***For client privacy, do not indicate the specific diagnosis.*** *Only sign if the client meets at least one of the four definitions.*

1. 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. 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:
   1. Is attributable to a mental or physical impairment or combination of mental and physical impairments;
   2. Is manifested before the person attains age 22;
   3. Is likely to continue indefinitely;
   4. 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
      8. 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. 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. Is a person whose sole impairment is alcoholism and/or drug addiction.

|  |  |
| --- | --- |
| **I certify that (1) I am licensed in the state of Maryland to diagnose and treat this client’s disabling condition, and (2) in my professional opinion, the applicant named above meets one of the definitions of a person with a disability given above.** | |
| Provider Printed Name |  |
| Provider License Type |  |
| Provider Signature |  |
| Date |  |