# DEPARTMENT OF COMMUNITY AFFAIRS

## Disability Verification

**Head of Household Name** _____

**Household Member**_____ **Date**_____

The person identified above is applying for or receiving assistance from the Georgia Department of Community Affairs (DCA) Housing Choice Voucher Program. We are required by federal regulations to verify the disability of a family member as defined by the U.S. Department of Housing and Urban Development (HUD). Attached is a statement from the family member authorizing the release of information from your agency. Please complete the information and return this form to the DCA Regional Office indicated below. Your prompt attention is appreciated.

The Head of Household has claimed the family member indicated above is disabled. HUD regulations define a person with a disability as:

1. The person has an inability to engage in any substantial gainful activity because of any physical or mental impairment that is expected to result in death or has lasted or can be expected to last continuously for at least 12 months; or, for a blind person at least 55 years old, inability because of blindness to engage in any substantial gainful activities comparable to those in which the person was previously engaged with some regularity and over a substantial period.

2. The person 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 such a nature that ability to live independently could be improved by more suitable housing conditions.

3. The person has a severe chronic disability that is attributable to a mental or physical impairment or combination of mental and physical impairments; is manifested before the person attains age 22; is likely to continue indefinitely; results in substantial functional limitations in three or more of the following areas of major life activity, including self-care, receptive and responsive language, learning, mobility, self-direction, capacity for independent living, economic self-sufficiency, and reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned or coordinated.

According to these definitions, the family member indicated above ☐ is or ☐ is not disabled.

Date disability began: _____

Applicable definition(s): ☐ 1 ☐ 2 ☐ 3

**I CERTIFY, IN MY PROFESSIONAL OPINION, THE INFORMATION LISTED ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I FURTHER CERTIFY MY PROFESSIONAL OPINION IS IN COMPLIANCE WITH ALL APPLICABLE LAWS, REGUALTIONS, STANDARD INDUSTRY PRACTICES, AND LICENSING GUIDELINES**

_____ _____
Name of Person Certifying (Print) Phone Number

_____ _____ _____
Signature Professional Title Date

_____
Name and Address of Practice