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| **PART 1: INSTRUCTIONS** |
| **Standard Disabling Condition Verification Process:*** To be eligible for all CoC funded PSH, evidence that one or more members of the household is diagnosed with a disabling condition must be documented in the participant file.
* To be eligible for a PSH unit that is dedicated to serve chronically homeless people, the disabling condition must be documented for an adult head of household, or, if there is no adult in the family, a minor head of household.
* This form can also be used for CoC-funded TH or other programs that have committed to serving disabled people.
* Complete all fields in Part 2.
* Complete all fields under the relevant option(s) in Part 3.
* Whenever possible, use the standard process of disability verification, which is option 1 or 2, third-party verification. These are preferable in order to preserve limited PSH and other housing resources for those with the most intensive service needs.

**COVID-19 Waiver Disabling Condition Verification Process** * When options 1, proof of Social Security (SSI/DI) or Veteran’s benefits, or 2, certification by a licensed clinician, are not possible, options 3 and 4 may be used so that applicants suspected of having a qualifying disability are not prevented from accessing PSH when third-party verification is not available during the COVID-19 outbreak.
* Option 3, intake or referral staff observation of a disability, may include, but not be limited to, directly witnessing any of the following:  an apparent physical disability; indicators of chronic substance use; the presence of severe mental or emotional impairment, paranoia, or disorientation to time and/or place; significant displays of the following: unusual patterns of speech, unusual behavior (e.g., exaggerated or extreme responses), unusual clothing (e.g. summer clothing in winter), etc.  Medications, prescriptions and medical records for treatment of a disability, including HIV/AIDS may also be considered.
* Please note, option 4, self-certification is acceptable to initiate assistance, while the usual third-party (options 1 or 2) or staff observation documentation (option 3) is obtained.
* Options 3 and 4 are available only through 9/30/20 and only in CoC projects in which the CoC grant recipient has notified HUD of intent to use the waiver - available for all DMHAS CoC PSH.
* For more information see [Memo on COVID-19 Related Waivers to CoC & ESG Requirements).](https://www.ctbos.org/wp-content/uploads/2020/04/Memo-2020.04.08-CoC-ESG-Waivers-v3.docx)

**For all participants:** * Attach all supporting documents, if available, to this form. (NOTE: This form does not require specifying disability.)
* Maintain this form and all supporting documents in the participant’s file.
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| **PART 2: GENERAL INFORMATION** |
| **Admitting CoC Agency Name:** | **CoC Project Name:** |
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| **Contact Person:** | **Contact Person Phone:** | **Contact Person Email:** |
|  |  |  |
| **Participant Name:** | **HMIS #** | **Date of****Birth** | **CoC Project****Entry Date** |
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| **Part 3: DISABLING CONDITION CERTIFICATION** |
| **Option #1: Social Security (SSI/DI) or Veteran’s Disability** |
| Evidence must include one of the following (Check One): A) Written verification from the Social Security Administration; OR B) Copies of a disability check (e.g., SSI, SSDI or Veterans Disability Compensation) |
| **ATTACH EVIDENCE OF EITHER A OR B TO THIS FORM** Check here to indicate that evidence has been attached.  |
| **Option #2: Verification by a Qualified Licensed Professional**(Certifying professional must be licensed by the State to diagnose and treat the qualifying condition.) |
| I, hereby, certify that (Insert Participant Name) has been diagnosed with at least one of the following:* A physical, mental, or emotional impairment, including an impairment caused by alcohol or drug abuse, post-traumatic stress disorder, or brain injury that: Is expected to be long- continuing or of indefinite duration; and substantially impedes the individual's ability to live independently; and could be improved by the provision of more suitable housing conditions; OR
* A developmental disability, as defined in section 102 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15002); OR
* The disease of acquired immunodeficiency syndrome (AIDS) or any condition arising from the etiologic agency for acquired immunodeficiency syndrome (HIV).

I also, hereby, certify that I am licensed by the State of Connecticut to diagnose and treat the condition that I am certifying above. |
|  I hereby certify that the above-named individual has been diagnosed with a DMHAS eligible disabling condition.  Check here to indicate that additional information regarding diagnosis has been attached (optional). (NOTE: This form does not require specifying disability.) |
| Notes (optional): |
| **Information About the Certifying Licensed Professional** |
| Signature of Licensed Professional: | Credentials: | Date: |
| Printed Name: | Organization: |
| License #: | Phone #: |
| **Option #3: Intake or referral staff observation** (only available through 9/30/20**)** |
| I have observed indicators that \_ (Insert Participant Name) meets the HUD definition of disability as described in Option #2 above. (NOTE: This form does not require specifying disability.) |
| Signature of Staff: | Title: | Date: |
| Printed Name: | Organization: |
| **Option # 4: Participant self-certification** (must be combined with Option #3 -only available through 9/30/20) |
| I hereby certify that I, (Insert Participant Name) meet the HUD definition of disability as described in Option #2 above. (NOTE: This form does not require specifying disability.) |
| Signature of Participant: | Date: |