HOUSING AUTHORITY OF THE COUNTY OF SAN DIEGO

3989 Ruffin Road, San Diego, CA 92123 Tel: (858) 694-4801 Toll-free: (877) 478-5478 Fax: (858) 467-9713 TDD: (866) 945-2207

DISABILITY/HANDICAP VERIFICATION

The United States Housing Act of 1937, as amended authorizes special consideration in Federally Funded Housing to a person who is permanently disabled or is an individual with handicaps who is permanently disabled.

Permanently Disabled is defined as: being unable to engage in any substantial gainful activity by reason of any medically determined physical or mental impairment which can be expected to last for a continuous period of not less than twelve (12) months.

Individual with Handicaps is defined as: a person having a physical or mental impairment which 1) is expected to be of long-continued and indefinite duration; 2) substantially impedes his or her ability to live independently; and, 3) is of such a nature that the disability could be improved by more suitable housing conditions.

The family status of _____ must be verified by an authorized health care professional or social worker in order for the Housing Authority to determine eligibility for Rental Assistance benefits.

APPLICANT INFORMATION AND CONSENT

I hereby authorize the release of the requested information in order to complete and verify my application for participation in the Mainstream Rental Assistance Program. Information may also be shared with the County of San Diego Health and Human Services Agency

It is with my understanding and consent that a photocopy of this authorization may be used for the purposes stated above. This authorization is valid for 15 months from the date of my signature.

_____ _____
PRINT APPLICANT NAME DATE

_____ _____
APPLICANT SIGNATURE LAST 4 OF SSN

CERTIFICATION OF PERMANENT DISABILITY BY HEALTH CARE PROFESSIONAL OR SOCIAL WORKER

Please certify that it is your firm ***professional opinion*** that the above-named party has a serious permanent medical condition that meets the definition of disabled and/or handicapped and that your certification is in compliance with all applicable laws, regulations, industry practices and licensing guidelines.

In my opinion, as defined above _____ ☐ IS ☐ IS NOT an individual who is
PATIENT NAME PERMANENTLY DISABLED as defined above.

_____ _____
PRINT NAME OF MEDICAL PROFESSIONAL/SOCIAL WORKER TITLE

_____ _____ _____
SIGNATURE LICENSE NO. DATE

_____ ( ) _____
ADDRESS CITY STATE ZIP CODE PHONE NUMBER

Do you require a specific accommodation to fully utilize the Agency's services? Yes ☐ No ☐