Horizon Housing Development Company
3001 Arsenal Street St. Louis, MO 63118
Phone: 314-865-0383 Fax: 314-865-0750

Verification of Disability

Instructions:

- *A qualified professional must complete and sign this form. Please see the other side of this form for a list of qualified professionals who may provide this verification.*

Program Information:
To be eligible for Horizon Housings ESG-CV Rental Assistance Program, an individual must meet certain disability standards.

An individual with a disability is a person who has:

- A disability as defined in Section 223 of the Social Security Act. This is an inability to engage in **any** substantial activity by reason of any medically determinable physical or mental impairment, which can be expected to last for a continuous period of not less than 12 months.
- 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.
- A developmental disability as defined in Section 102(7) of the Developmental Disabilities Assistance and Bill of Rights Act.

Household Information

Head of Household Name:	**Last four numbers of SSN:**
Name of Individual with Disability:	**DOB:**

Certification

Based on the above definition(s), it is my professional opinion that:

Name of Individual: _____

☐ Is a person with a disability ☐ Is <u>not</u> a person with a disability

This disability began about:_____.

Warning: *Section 1001 of Title 18 of the US Code makes it a criminal offense to make any willful false statements or misrepresentations to any Department or Agency of the United States as to any matter within its jurisdiction, punishable by fine not to exceed $10,000 and/or imprisonment of not more than 5 years.*

I certify the information in this Verification of Disability is true and accurate.

Signature:		Date:
Phone:	Fax:	Email:

Mission:
To assist in providing housing services to St. Louis City homeless individuals with disabilities.

Funded by St. Louis Office of Developmental Disability Resources, Mental Health Board & Continuum of Care

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Qualifications to Complete the Verification of Disability

Below is a list of professionals qualified to complete the *Verification of Disability*. If you have a degree/license/accreditation that is not listed and you believe you are qualified to assess an individual's disability status, please contact us at 314-865-0383.

Title	Acronym
Certified Alcohol and Drug Counselor Level 3	CADC III
Doctor of Chiropractic Medicine	DC
Doctor of Osteopathic Medicine	DO
Licensed Clinical Social Worker	LCSW
Licensed Nurse Practitioner Psychiatric Mental Health Nurse Practitioner Certified Nursing Specialist Family Nurse Practitioner	LNP PMHNP CNS FNP
Medical Doctor	MD
Physician's Assistant	PA
Qualified Mental Health Professional	QMHP

Additional Comments:

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AUTHORIZATION FOR DISCLOSURE/RELEASE OF CONSUMER INFORMATION

I _____ authorize and request:
(Name of Consumer, Parent, Guardian/Legal Representative)
To **disclose/release information**
__Horizon Housing Development_____ To: _____

____3001 Arsenal St. Louis, MO. 63118__ _____
(Name and address of agency requesting information) (Name and address of agency releasing information)

Individual whose information being requested:
Name: _____
Date of Birth: _____
Social Security Number: _____

The Purpose of this Disclosure is:

- ☐ **Service Planning** ☐ **Eligibility Determination**
- ☐ **Continuity of Services/Care** ☐ **Consumer Request**
- ☐ **Other _____**

The Specific Information to be disclosed is:

- ☐ **Financial Information to Determine Eligibility** ☐
- ☐ **Medical Psychiatric Assessment** ☐
- ☐ **Educational Testing, IEP, transcript, grading reports**
- ☐ **Other_____**

1. I understand that my medical/health/educational information records are confidential. I understand that by signing this authorization, I am allowing the release of medical/health information. The protected health information (PHI) in my medical records includes mental/behavioral health information. In addition, it may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), other communicable diseases, and alcohol/drug abuse.

2. Alcohol and drug abuse information records are specifically protected by Federal regulations (42 CFR 2) and by signing this authorization without restrictions I am allowing the release of any alcohol and/or drug information records (if any) to the agency or person specified above. Please sign if you are authorizing the release of alcohol and drug abuse information:

_____
(Name of Consumer, Parent, Guardian/Legal Representative)

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3. THE FOLLOWING STATEMENT APPLIES TO ANY ALCOHOL AND/OR DRUG ABUSE TREATMENT INFORMATION RECORDS THAT WE DISCLOSE. Prohibition on Disclosure: This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulations (42 CFR Part 2) prohibit you from making further disclosure of it without the specific written authorization of the person to whom it pertains, or as otherwise specified by such regulations. A general authorization for disclosure of medical or other information is NOT sufficient for this purpose.

4. This authorization becomes effective on _____. This authorization automatically expires on the following date_____. If I fail to specify an expiration date, this authorization will expire in one year.

5. I have received a copy of this agency's Notice of Privacy Practices.

My signature below acknowledges that I have read, understand, and authorize the release of my PHI.

_____ _____
Consumer/Guardian Signature Date

_____ _____
Witness Date

NOTICE OF REVOCATION

I, _____ (Consumer) hereby revoke my authorization of this disclosure of information to the agency/person listed above. This revocation effectively makes null and void any permission for disclosure of information expressly given by the above authorization. I understand that any actions based on this authorization, prior to revocation, will not be affected.

_____ _____
Consumer/Guardian Signature **Date**

_____ _____
Witness **Date**

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