**\*Release for Verification of Disabling Condition**

Participant Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Agency requesting release: \_\_ \_\_\_\_\_\_\_\_\_\_\_

Agency Staff requesting release: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone No.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PENALTIES FOR MISUSING THIS CONSENT:

Title 18, Section 1001 of the U.S. Code states that a person is guilty of a felony for knowingly and willingly making false or fraudulent statements to any department of the United States Government. HUD, the PHA and any owner (or any employee of HUD, the PHA or the owner may be subject to penalties for unauthorized disclosures or improper uses of information collected based on the consent form. Use of the information collected based on this verification form is restricted to the purposes cited above. Any person who knowingly or willfully requests, obtains or discloses any information under false pretenses concerning an applicant or participant may be subject to a misdemeanor and fined not more than $5000. Any applicant or participant affected by negligent disclosure of information may bring civil action for damages, and seek other relief, as may be appropriate, against the officer or employee of HUD, the PHA or the owner responsible for the unauthorized disclosure or improper use. Penalty provisions for misusing the social security number are contained in the Social Security Act at 42 U.S.C. 208(f) (g) and (h). Violation of these provisions are cited as violations of 42 U.S.C. 408(f) (g) and (h).

PARTICIPANT RELEASE

RELEASE: I hereby authorize the release of the requested information. Information obtained under this consent is limited to information that is no older than 12 months. There are circumstances, which would require the owner to verify information that is up to 5 years old, which would be authorized by me on a separate consent, attached to a copy of this consent.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Participant Signature Date

*\*HIPPA Laws require medical information only be released to the person requesting their records & that person be physically present when obtaining their records. Otherwise, a release must be provided if person is not physically present for their records request. Provide this form* ***with*** *Verification of Disability form* ***ONLY*** *when participant is unable to physically obtain records in person.*

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| Participant Name: |
| *The above named participant is applying for PSH Assistance. To qualify for enrollment participant must be:** Homeless and lack the resources to obtain housing on own
* Coming from the streets or places not meant for human habitation or coming from an emergency shelter, domestic violence shelter, or motel/hotel paid for by a third-party organization in lieu of an emergency shelter
* Homeless one continuous year, or for a combined total of 12 months within the past 3 years
* **Have a disabling condition. Disabling conditions are defined below;**
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| * 1. A person shall be considered to have a disabling condition if said person has a physical, mental, or emotional impairment, which is expected to be of long continued and indefinite duration; substantially impedes his/her ability to live independently; and of such a nature that such inability could be improved by a more suitable housing condition, or;
	2. A person will also be considered to have a disabling condition if she/he has a developmental disability, which is a severe, chronic disabling condition that:

 i. Is attributable to a mental or physical impairment or combination of mental and physical impairments;ii. Is manifested before the person attains age 22;iii. Is likely to continue indefinitely;iv. Results in substantial functional limitations in three or more of the following areas of major life activity: Self-care, Receptive & expressive language, learning, mobility, capacity for independent living, or economic  self- sufficiency; andv. Reflects the person’s need for a combination and sequence of special, interdisciplinary, or generic care,  treatment, or other services which are lifelong or extended duration, and are individually planned and  coordinated, or;**3.** Notwithstanding the preceding provisions of this paragraph, the term ‘persons with disabling condition’ includes:i. Two or more persons with disabling conditions living together, or;ii. One or more persons living with a head of household who is determined to have a disabling condition. |
| **THIS SECTION TO BE COMPLETED BY A LICENSED PROFESSIONAL ONLY:**I have reviewed the definition(s) above and determined that the above-named participant has the following disabling condition(s) that meets one or more of the defined criteria (mark all that apply): [ ]  Alcohol Abuse [ ]  Developmental Disability [ ]  Drug Abuse [ ]  HIV/AIDS [ ]  Mental Illness [ ]  Physical Disability  [ ]  ***Doesn’t*** Meet the Above Criteria [ ]  Don’t Know [ ]  Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| Diagnosis: | Code: | Diagnosis: | Code: |
| Diagnosis: | Code: | Diagnosis: | Code: |
| Signed: | Date: |
| Name of Licensed Professional (Printed): | License #: |
| **\*Professional Title**: [ ]  Physician [ ]  Psychiatrist [ ]  Psychologist [ ]  Nurse Practitioner  [ ]  Other (Please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\***Individual that signs this form **MUST** be licensed to diagnose and treat the condition(s) indicated. |

**Verification of Disabling Condition****Permanent Supportive Housing (PSH) Third-Party Homeless Verification**

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| Participant Name: |
| ***I, the above-named participant, hereby authorize the release of the requested information required for PSH Third-Party Homeless Verification.*** |
| Participant Signature: | Date: |
| **The above-named participant is applying to receive the services of a Permanent Supportive Housing(PSH) funded program serving chronically homeless persons. To qualify, the participant must be determined to be chronically homeless as defined by the U.S. Department of Housing and Urban Development. Information provided on this form will be used for the purpose of verifying the chronic homeless status eligibility for the above-named participant***.*  |
| Agency Providing Third-Party Verification: |
| Agency Staff (Printed Name): |
| [ ]  Our agency has been providing outreach or street-based services to this person living on the streets or place not meant for human habitation. [ ]  Our agency’s engagement date was (MM/DD/YYYY): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  Our agency has been providing emergency shelter and services. [ ]  Our agency’s engagement date was (MM/DD/YYYY): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  Our agency has been providing transitional housing and services. [ ]  Our agency’s engagement date was (MM/DD/YYYY): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  Our agency certifies that this person/household initially came to our program from: [ ]  The streets, place not meant for human habitation or; [ ]  Emergency shelter |
| [ ]  Our agency is aware of the following episodes of homelessness for the above-named participant:

|  |  |  |
| --- | --- | --- |
| **Time Period** | **Location** | **Documented?** |
| *Example – January 1, 2007* | *Example- Ohio Shelter* | *Example-* *[x]  yes* *[ ]  no* |
|  |  | [ ]  yes [ ]  no |
|  |  | [ ]  yes [ ]  no |
|  |  | [ ]  yes [ ]  no |
|  |  | [ ]  yes [ ]  no |
|  |  | [ ]  yes [ ]  no |

 |
| Agency Staff Signature: | Date: |