VERIFICATION OF DISABILITY FORM

RE:

Your name has been provided by the above referenced applicant or resident as an individual qualified to verify their disability.

The applicant has identified to the Authority that they possess a disability that effects one or more of the following major life functions:

☐ Self Care	☐ Manual Tasks	☐ Walking
☐ Seeing	☐ Hearing	☐ Speaking
☐ Breathing	☐ Learning	☐ Working

☐ Other: _____

This form specifically relates to verification of the functional limitation(s) identified above.

The questions listed below are designed to collect the information the Authority requires to verify (in a manner consistent with Authority policy and regulation) the existence of a disability.

1. Are you licensed in the Commonwealth of Massachusetts as a medical practitioner, and are you responsible for medical diagnosis and treatment? ☐ Yes ☐ No

2. Are you the primary care medical care provider for the functional limitation (s) indicated by the program applicant? ☐ Yes ☐ No

3. Can the condition which caused the functional limitation be considered chronic by current medical standards? ☐ Yes ☐ No

4. Is the condition likely to be of long and continued duration? ☐ Yes ☐ No

5. Is there a current, generally accepted drug treatment, prosthesis, or other form of medical intervention that could mitigate the condition and bring the individual into a normal range of functioning? ☐ Yes ☐ No

6. Are there one or more special features for a housing unit or development that would mitigate the impact of the condition:

Wheelchair Unit Dimensions	☐
Sensory Impairment Unit Adaptations	☐
First Floor Location	☐
Specific Location in Order to Access a Supportive Service	☐
Indicate development if known _____	☐
No Special Feature Required	☐

By signing this form you are certifying that the above referenced applicant or resident has an impairment which:

(i) is expected to be of long continued and indefinite duration
(ii) substantially impeded his/her ability to live independently and
(iii) is of such a nature that such ability could be improved by more suitable housing conditions.

These conditions are consistent with the definition which cover public housing programs which can be found at section 3 (b)(3), United Stated Housing Act of 1937, as amended: Lower Income Public Housing; and Section 8, United States Housing Act of 1937, as amended: Housing Assistance Payment Program.

This certification is essential to the determination that the above referenced applicant is eligible for occupancy in an Authority development as a disabled individual. Misrepresentation by the applicant of disabled status is considered a material defect in their application, and the applicant will be removed from the program Waiting List. The resident will have their Request for Transfer denied and will be pursued consistent with the requirements of the BHA Lease. The Authority will no longer accept verifications of disability from any medical practitioner who assists in misrepresentation of disabled status.

Physicians Signature _____ **Date** _____

Physicians Printed Name _____