Housing Authority of the City of Austin

1124 South IH 35, Austin, TX 78704
(512) 477-1314 Fax (512) 494-0686

DISABILITY / HANDICAP VERIFICATION FORM

To: _____

Attn: _____

Address: _____

_____

From: _____

_____

Date: _____

Fax: **512-494-0686**

Re:
Client _____ Client #: _____
Address: _____ _____

_____

The Housing Choice Voucher Program, which is funded by the U.S. Department of Housing and Urban Development (HUD), assists the person named below. HUD requires a Public Housing Authority to verify all information that is used in determining this person's eligibility, admissibility, income allowances, and necessary accommodations. The participant has signed a release giving you permission to supply us with this information. Please fill out the forms and return them at your earliest convenience.

A final determination cannot be made until you have completed the attached forms and return to our office by mail or by fax.

Thank you for your cooperation.

Sincerely,

Housing Authority of the City of Austin
1124 South IH 35, Austin, TX 78704
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CERTIFICATION OF DISABILITY / HANDICAP

The Housing Authority of the City of Austin is required by HUD to verify the disability of participants claiming to be disabled to determine eligibility for the housing and to compute rent. The participant has signed a release form below giving you permission to supply us with this information. Please fill out the form below and return it at your earliest convenience.

The Department of Housing and Urban Development defines a disabled person in 3 ways:

(1) A disabled person is one with an inability to engage in any substantial gainful activity because of any physical or mental impairment that is expected to result in death or has lasted or can be expected to last continuously for at least 12 months; or for a blind person at least 55 years old, inability because of blindness to engage in any substantial gainful activities comparable to those in which the person was previously engaged with some regularity and over a substantial period.

(2) A developmentally disabled person is one with a severe chronic disability that:
   (a) is attributable to a mental and/or physical impairment;
   (b) as manifested before age 22;
   (c) is likely to continue indefinitely;
   (d) results in substantial functional limitations in three or more of the following areas: capacity for independent living, self-care, receptive and expressive language; learning, mobility, self-direction, and economic self-sufficiency AND
   (e) requires special interdisciplinary or generic care treatment, or other services which are of extended or lifelong duration and are individually planned or coordinated.

(3) A disabled person is also one who has a physical, emotional or mental impairment that:
   (a) is expected to be of long-continued or indefinite duration;
   (b) substantially impedes the person's ability to live independently;
   (c) is such that the person's ability to live independently could be improved by more suitable housing conditions.

I hereby certify I am a professional competent to render the opinion and knowledgeable about the person's situation. The person _____ (person signing the release below) should be considered disabled in accordance with definition number _____ above.

Name and Title _____

Signature _____

Phone _____ Date _____

TENANT/APPLICANT RELEASE

I,_____ , hereby authorize the release of the requested
(print name)
information.

X _____ Date
(Signature)

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CERTIFICATION OF NEED FOR PERSON WITH DISABILITIES

I certify that the person named below requires the following special accommodations to ensure that the full benefit of the Housing Choice Voucher program services and activities are available.

SPECIAL ACCOMMODATIONS REQUESTED (IF ANY):

☐ Needs a live-in aide

☐ Requests consideration of attendant care expenses (not a live aid).

☐ Needs a larger bedroom size

☐ Other request: _____

THE AVAILABILITY OF THE CARE, AUXILIARY APPARATUS, OR ACCOMMODATION ENABLES:

☐ The person with a disability named below to work, and / or

☐ Enables other household member(s) to work, and / or

☐ Explanation of other accommodation

_____

_____

DURATION OF DISABILITY:

☐ Based upon my examination, the above-stated condition(s) will, in all reasonable medical probability, continue for_____*(State expected duration of the condition(s))*

☐ Based upon my education, experience, expertise, and my examination of the above-named individual, as well as, reasonable medical probability, it is my professional opinion that the person named below suffers from a **permanent disability**.

I hereby certify I am a professional competent to render the opinion and knowledgeable about the person's situation.

Name and Title _____

Signature _____

Phone _____ Date _____

PARTICIPANT RELEASE

I, _____, hereby authorize the release of the requested
(print name)
information.

X _____ Date _____
(Signature)

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ATTENDANT CARE EXPENSES VERIFICATION

To: _____ From: _____

Attn: _____

Address: _____ Date: _____

_____ Fax: **512-494-0686**

Public Housing Authorities are required by Federal Law to verify the cost of attendant care for residents with disabilities so that the costs may be taken into consideration when computing rent. You will note that the resident has signed a release form below, giving you permission to supply us with this information. If you could fill out the form below and return it, it would be most appreciated.

VERIFICATION

I hereby certify that I provide care for _____(disabled person) and that this care enables_____(family member) to earn employment income.

During the year beginning _____ and ending _____, I will be providing care _____ hours per week, for _____ weeks of the year.

My rate of pay is _____ per hour, and I will be paid once every _____. Hours when I will be providing care area as follows:

Monday:	_____	hours
Tuesday:	_____	hours
Wednesday:	_____	hours
Thursday:	_____	hours
Friday:	_____	hours
Saturday:	_____	hours
Sunday:	_____	hours

Name and Title _____

Signature _____

Phone _____ Date _____

PARTICIPANT RELEASE

I,_____ , hereby authorize the release of the requested
(print name)
information.

X _____ Date _____
(Signature)