SACRAMENTO STEPS FORWARD
Ending Homelessness. Starting Fresh.

DISABILITY CERTIFICATION

The Disability Certification is used to affirm that an individual is disabled and is used only for the purpose of qualifying for housing assistance under a program of the U.S. Department of Housing and Urban Development (HUD).

Client Name: ______________________________________ **HMIS UID** (or DOB): ______________________

Please complete either Section 1 or 2.

Section 1. Completed by HOMELESS SERVICE PROVIDERS, HOUSING PROVIDERS, or HEALTH CARE WORKERS only

Required: *Attach proof of disability by written verification from the Social Security Administration (i.e. SSI, SSDI) or receipt of a disability check (e.g. Veteran Disability Compensation).*

☐ Individual has a disability that has been verified by the Social Security Administration or by receipt of a disability check.

I certify that the above information is true and accurate. I have enclosed acceptable evidence as required under 24 CFR 578.103. I understand that knowingly or willingly making false or fraudulent statements are subject to punishment.

Signature: ____________________________________ Date: _________________________

Printed Name: ____________________________________

Agency Name: ____________________________________ Job Title: _________________________

Section 2. Completed by the following Licensed Professional by the State of California ONLY:
MD or DO, PsyD or PhD, LMFT, LCSW, LPCC, NP or FNP, PA*
*For Physician Assistants, please include name and license number of your supervising physician.

Required: *ONLY a professional licensed by the State of California to diagnose and treat the qualifying disability can verify the disability (24 CFR 578.103).*

☐ Individual has a disability, as defined in the HEARTH Act of 2009, which means:

i) A condition that is expected to be long-continuing or of indefinite duration; ii) substantially impedes the individual's ability to live independently; iii) could be improved by the provision of more suitable housing conditions; AND is one of the following:

- a physical, mental or emotional impairment, including an impairment caused by alcohol or drug abuse, post-traumatic stress disorder, or brain injury
- a developmental disability as defined in Section 102 of the Developmental Disabilities Assistance Bill of Rights Act of 2000 (42 U.S.C. 15002)
- the disease of AIDS or any conditions arising from the etiologic agent for AIDS, including HIV

I certify that the above information is true and accurate. I have enclosed acceptable evidence as required under 24 CFR 578.103. I understand that knowingly or willingly making false or fraudulent statements are subject to punishment.

Signature: ____________________________________ Date: _________________________

Printed Name: ____________________________________ **License #:** _________________________

Agency Name: ____________________________________ Job Title: _________________________

(PA's only) Supervising Physician Name: ____________________________________ **(PA's only)** Supervising Physician License #: _________________________