DISABILITY VERIFICATION

THIS SECTION TO BE COMPLETED BY MANAGEMENT AND EXECUTED BY TENANT

TO:

_____

_____

_____

FROM/RETURN TO:

_____

_____

_____

E-Mail: _____Fax:_____

Qualifying household member's name:

_____

Thank you for your prompt response. All information is confidential.

Please contact _____

at _____ if you have any questions.

PERMISSION FOR RELEASE OF INFORMATION

You do not have to sign this form if either the requesting organization or the organization supplying the information is left blank. 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.

_____ _____

Signature Date

"DISABILITY" means:

A physical or mental impairment that substantially limits one or more of the major life activities of an individual, such as not being able to care for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, or learning.

THIS SECTION TO BE COMPLETED BY KNOWLEDGEABLE INDIVIDUAL

I certify that the above referenced applicant falls within this Disability definition.

I certify this information as the applicant's (please check the appropriate box):

☐ Physician

☐ Relative

☐ Social Worker

☐ Caregiver

☐ Other _____

_____ _____

Signature Date