Department of Mental Health and Addiction Services
Supportive Housing Programs

Disability Verification Form

Applicant Name:	
Date Form Completed:	
Referral Agency:	
Contact Name:	Contact Phone No.:

Type of Disability

- ☐ Serious Mental Illness
- ☐ Chronic Substance Abuse
- ☐ Co-Occurring / Dual Diagnosis
- ☐ AIDS and Related Diseases
- ☐ Other (Please Specify): ____

The following information must be completed and signed by a licensed mental health professional, (e.g. Psychiatrist, Psychologist, Nurse, Social Worker, etc.) or a M.D.

Please attach a statement or an assessment attesting to the current condition (consistent with the Type of Disability checked above) of the applicant to this program. Please be as specific as possible documenting the limiting factors of the condition (i.e. functional deficits):

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Disability Entitlement Status

- ☐ Yes (Currently Receiving SSI/SSDI)
- ☐ No

____ ____
Signature/License No. Date