CHAMP
DISABILITY VERIFICATION FORM

The Knoxville-Knox County Homeless Coalition's Coordinated Housing Assessment and Match Plan (CHAMP) and local Permanent Supportive Housing providers are required to verify the disability status of homeless individuals in order to determine eligibility for housing. The applicant has signed a release form below giving you permission to supply this information. This individual is not currently receiving Social Security Disability Income or Supplemental Social Security Income. He/she is seeking the "homeless person with a disability status" under the following HUD guidelines. *Please note HUD guidelines do not require the level of impairment needed to qualify as disabled by the Social Security Administration.*

The Department of Housing and Urban Development defines a HOMELESS INDIVIDUAL WITH A DISABILITY as an individual who is homeless and:

1. has a physical, mental, or emotional impairment that
    a. is expected to be of long-continuing or indefinite duration, including an impairment caused by alcohol or drug abuse, post-traumatic stress disorder, brain injury and/or the disease of acquired immunodeficiency syndrome or any condition arising from the etiologic agent for acquired immunodeficiency syndrome;
    b. substantially impedes his/her ability to live independently AND;
    c. is of a nature that could be improved by the provision of more suitable housing conditions.

    ⊢OR⊣

2. is a person with a developmental disability as defined in section 102 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15002) i.e. is a person with a severe chronic disability that:
    a. is attributable to a mental or physical impairment or a combination of mental or physical impairments;
    b. is manifest before the person attains 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 geriatric care treatment, or other services which are of extended or lifelong duration and are individually planned or coordinated.

This verification must be completed by an individual licensed to diagnose and treat the condition identified.

Name and Title of medical professional: _____

I certify that the patient named below meets ***all the criteria*** to be considered disabled under ***definition number*** _____

Signature of medical professional: _____ Date: _____

APPLICANT RELEASE:

Print Name: _____ Last 4 digits of SSN: _____

I hereby authorize the release of the requested information to CHAMP and housing providers in order to secure housing through the CHAMP process.

Signature: _____ Date: _____