DOCUMENTATION OF DISABILITY - PHYSICIAN / CNS STATEMENT

Applicant Name _____

Date of Birth _____

The client named above is applying for housing through the Indianapolis Housing Committee. The criteria for inclusion in this program is that the person has a disabling condition. Please indicate below if this individual has a disabling condition:

The disabling condition must meet the following three criteria

- ☐ The disabling condition is expected to be of long-continued and indefinite duration
- ☐ The disabling condition substantially impedes an individual's ability to live independently
- ☐ The disabling condition is such that ability could be improved by more suitable housing conditions

☐ **This individual has a condition that limits the individual's ability to work**

Explain	

☐ **This individual has a condition that limits the individual's ability to perform at least three or more activities of daily living. Those activities of daily living are (limitations must be explained):**

- ☐ Self care
- ☐ Receptive and expressive language
- ☐ Learning
- ☐ Mobility
- ☐ Self-direction
- ☐ Capacity for independent living (functional assessment needed)
- ☐ Economic self-sufficiency

situation. Please indicate below how this individual meets the criteria.

- ☐ Diagnosis of serious mental illness

  Diagnosis: _____
- ☐ Diagnosis of addiction

  Diagnosis: _____
- ☐ HIV+

  CD4 count and viral load: _____

  (additional verification needed)
- ☐ Individual is fleeing a domestic violence situation

  (additional verification from shelter will be required)
- ☐ Medical/Physical

  Disabling condition diagnosis: _____

_____ _____

Physician/CNS written name and credentials Date

_____ _____

Physician/CNS signature Date

EQUAL HOUSING OPPORTUNITY

Note: form must be signed by credentialed, licensed person who can diagnose without confirming signature.

Effective 9/7/17