

HUD DISABILITY DOCUMENTATION

Disability Documentation for: _____
Print Name Here

The person listed above has been diagnosed by our program with the following disabling condition(s). Check all that apply.

- | | |
|---|--|
| <input type="checkbox"/> Serious Mental Illness | <input type="checkbox"/> Chronic physical illness/disability |
| <input type="checkbox"/> Substance use disorder | <input type="checkbox"/> Developmental disability |
| | <input type="checkbox"/> HIV/AIDS |

The diagnosis is:

Approximate date of on-set of disability: _____
Month/Year

Date of last diagnosis: _____
Month/Year

x

Signature of Qualified Person

x

Title

x

Date

This form must be printed on Agency letterhead and signed by a qualified person:
LBP, LPC, LCSW, LMFT, PhD, MD or DO.