**New Jersey Department of Community Affairs**
**Division of Housing**
**Continuum of Care Program**

# VERIFICATION OF DISABILITY

________________________________________________
(Individual Claiming Disability)

The above-named person is a applying for participation Continuum of Care program operated by the New Jersey Department of Community Affairs. To determine the applicant's eligibility, we must verify that he/she is disabled as defined by the U.S. Department of Housing and Urban Development (HUD). HUD regulations define disability as follows:

A. A person with a physical, mental, or emotional impairment that:
   1. Is expected to be of long continued and indefinite duration;
   2. Substantially impedes his or her ability to live independently; and
   3. Is of such a nature that such ability could be improved by more suitable housing conditions

B. A severe, chronic developmental disability which:
   1. Is attributable to mental or physical impairment or combination of mental and physical impairments;
   2. Is manifested before the person attains age twenty-two;
   3. Is likely to continued indefinitely;
   4. Results in substantial functional limitations in three or more of the following areas of major life activity: (i) self-care, (ii) receptive and expressive language, (iii) learning, (iv) mobility, (v) self-direction, (vi) capacity for independent living, and (vii) economic self-sufficiency; and
   5. Reflects the person's need for a combination of and sequence of special, interdisciplinary, or generic care, a treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated.

## CERTIFICATION OF DISABILITY

I certify that the above referenced person is disabled according to the above definition(s) I have indicated.

**(Please check the definition(s) that applies)  [   ] A; [   ] B; and describe your patient's condition:**

________________________________________________________________________

Estimated duration that the disability will continue: ________________________________

Physician's Name: ___________________________________________________

Physician's License Number: ____________________________________________

Address: ____________________________________________________________

_________________________________________________________________

Telephone Number: __________________________________________________

Physician's Signature: _________________________________________________

Date of Signature: ___________________________________________________

________________________________ ________________
Client Authorization Date