New Jersey Department of Community Affairs
Division of Housing & Community Resources
Continuum of Care

VERIFICATION OF DISABILITY

_____
(Individual Claiming Disability)

The above-named person is a applying for participation in the 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.

VERIFICATION 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