SC State Housing Finance and Development Authority
Verification of Disability

To the Health Care Provider: _____

As an applicant/participant in the HUD Section 8 Rental Assistance program, I am required to provide information concerning my Disability. This status will be used in determining program eligibility and rent calculation purposes. Please complete this form and return it directly to the address or FAX number listed below. Your prompt cooperation in supplying the requested information is appreciated. If you have any questions, please do not hesitate to contact the Housing Program Coordinator (HPC) at the telephone number provided.

Mailing Address:

SC State Housing Finance & Development Authority
Voucher Program –_____County HPC
300-C Outlet Pointe Blvd
Columbia, SC 29210

Phone: (803) 896-_____
Fax: (803) 551-_____

Name of Participant: _____ SSN: _____

Signature Authorizing Release of Information: _____ Date:_____

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TO BE COMPLETED BY HEALTH CARE PROVIDER

I hereby certify that the above referenced applicant/participant is disabled as defined in 42 U.S.C. 423(d) or has a developmental disability as defined in the Developmental Disabilities Assistance and Bill of Rights Act of 2000, 42 U.S.C. 15002(8).

42 U.S.C. 423(d) defines disability as:

1. Inability to engage in any substantial, gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months; or
2. In the case of an individual who has attained the age of 55 and is blind (within the meaning of "blindness" as defined in Section 416 (i) (1) of this title), inability by reason of such blindness to engage in substantial gainful activity requiring skills or abilities comparable to those of any gainful activity in which he/she has previously engaged with some regularity and over a substantial period of time.

42 U.S.C. 15002(8) defines developmental disability as a severe, chronic disability that:

Is attributable to a mental or physical impairment or combination of mental and physical impairments; is manifested before the individual attains age 22; is likely to continue indefinitely; results in substantial functional limitations in 3 or more of the following major life activities; (i) self care, (ii) receptive and expressive language, (iii) learning, (iv) mobility, (v) self-direction, (vi) capacity for independent living, (vii) economic self-sufficiency, and reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated.

Signature of Health Care Provider	Date
Printed Name	Title
Street Address	SC License Number (if applicable)
City, State and Zip Code	Telephone Number

If using a Telecommunications Device for the Deaf (TDD), please call: (803) 896-8831.

Warning: 18 U.S.C. 1001 provides, among other things, that whoever knowingly and willfully makes or uses a document or writing containing false, fictitious, or fraudulent statement or entry, in any matter within the jurisdiction of any department or agency of the United States, shall be fined not more than $10,000 or imprisoned for not more than five years, or both.