# SECTION 8 MAINSTREAM VOUCHER PROGRAM

**REQUEST FOR VERIFICATION OF HANDICAP OR DISABILITY**

(Issued under Section 8 of the U.S. Housing (program) Act of 1937,

Failure to comply could result in the termination of benefits.)

LICENSED HEALTH PROFESSIONAL AUTHORIZATION:

## You are authorized to release information concerning my handicap or disability to Housing Services Mid Michigan.

Patient’s Signature Date

## Federal law gives special consideration to a person or family of a person who is handicapped or disabled in order to be eligible to receive federally aided housing. For the purpose of qualifying for such special consideration at least one of the heads of the household must:

1. be unable to engage in any substantial gainful activity by reason of any medically determined physical or mental impairment which can be expected to last for a continuous period of not less than 12 months; or
2. in the case of an individual who is 55 years of age and is blind, be unable by reason of blindness to engage in substantial gainful activity requiring skills or abilities comparable to those of any gainful activity in which he has previously engaged with some regularity and over a substantial period of time; or
3. be a handicapped person which is defined as a person having a physical or mental impairment which:
4. is expected to be of a long-continued and indefinite duration, and
5. substantially impedes the ability to live independently, and
6. is of such a nature that such ability could be improved by more suitable housing conditions.
7. be developmentally disabled which means a severe, chronic disability of a person which:
8. is attributable to a mental or physical impairment or combination of mental and physical impairments; and
9. is manifested before the person is 22; and
10. is likely to continue indefinitely; and
11. results in substantial functional limitation in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, ability, self-direction, capacity for independent living, and economic self-sufficiency, and reflects the persons need for a combination and sequence of special inter-disciplinary, or generic care, treatment, or other services which are of life-long or extended duration and are individually planed and coordinated.

CERTIFICATION OF HANDICAP OR DISABLITY

## **Instructions: Only a licensed health professional may complete this form.**

### In my opinion,

(Name of Patient)

* is is not handicapped as defined on the previous page for a long-continued and

indefinite duration. An explanation of the nature of the handicap is:

is is not disabled as defined on the previous page for a continuous period of not less

than 12 months. An explanation of the disability is:

* This patient is permanently handicapped or disabled.

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**As a duly licensed health professional, I certify the information given is correct.**

### Type or Print Name of Health Professional Licensed as a

Signature of Health Professional Date Signed

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Street Address City State Zip Code

\_(\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone Number

**Please mail or fax this form to the above address**

**Attn: Section 8 Program**

*"HSMM is an equal opportunity provider”*

