IF RECEIVING SSI or SSDI BENEFITS – DO NOT FILL OUT

HOUSING SERVICES MID MICHIGAN
319 S. Cochran, P.O. Box 746
Charlotte, Michigan 48813
517/541-1180 • 517/541-0269 fax

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:

A. 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

B. 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

C. be a handicapped person which is defined as a person having a physical or mental impairment which:
   1. is expected to be of a long-continued and indefinite duration, and
   2. substantially impedes the ability to live independently, and
   3. is of such a nature that such ability could be improved by more suitable housing conditions.

D. be developmentally disabled which means a severe, chronic disability of a person which:
   1. is attributable to a mental or physical impairment or combination of mental and physical impairments; and
   2. is manifested before the person is 22; and
   3. is likely to continue indefinitely; and
   4. 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 health professional licensed by the Bureau of Occupational and Professional Regulation 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.

_____
_____
_____

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

_____
Street Address City State Zip Code

_(____)_____
Telephone Number

Please mail or fax this form to the above address
Attn.: Mainstream Voucher Program