

**Verification of Disability
Special Needs Set-Aside**

The person signing below verifies that the following individual

_____ has a disability or special need as checked below.
(Individuals Name)

We are releasing this information with the approval of the above individual for the purpose of helping him or her acquire housing.

Check all that apply

- | | |
|-----------------------------|-----------------------------------|
| _____ Severe Mental Illness | _____ Traumatic Brain Injury |
| _____ Mental Retardation | _____ Physical Disability |
| _____ Substance Addiction | _____ Victim of Domestic Violence |
| _____ HIV/AIDS | _____ Other (Specify) |

We attest that our agency and the individual signing below are qualified to make this determination.

(Agency)

(Individual completing form)

(Date)

(Position with agency)

(Professional qualifications/designations such as MSW, Psychologist, Qualified Mental Health Professional, Qualified Substance Abuse Professional)

By signing below, I authorize the release of this information.

Applicant/Tenant Date

Applicant/Tenant Date