# Housing Authority of the City of Fulton Missouri

350 Sycamore St.—P.O. Box 814—Fulton, Missouri 65251

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## Disability Verification Form

Public Housing Authorities are required to verify the disability of applicants/residents claiming to be disabled to determine the eligibility for the housing and to compute rent. The resident has signed a release form below giving you permission to supply us with this information. Please fill out the form below and return it at your earliest convenience.

Anne Johnson, Executive Director Fulton Housing Authority

The Department of Housing and Urban Development defines a disabled person in 3 ways:

(1) A disabled person is one with an inability to engage in any substantial gainful activity because of any physical or mental impairment that is expected to result in death or has lasted or can be expected to last continuously for at least 12 months; or for a blind person at least 55 years old, inability because of blindness to engage in any substantial gainful activities comparable to those in which the person was previously engaged with some regularity and over a substantial period.

(2) A developmentally disabled person is one with a severe chronic disability that:
  - (a) Is attributable to a mental and/or physical impairment;
  - (b) as manifested before age 22;
  - (c) is likely to continue indefinitely;
  - (d) results in substantial functional limitations in three or more of the following areas; capacity for direction, and economic self-sufficiency AND
  - (e) requires special interdisciplinary or generic care treatment, or other services which are of extended or lifelong duration and are individually planned or coordinated.

(3) A disabled person is also one who has a physical, emotional or mental impairment that:
  - (a) Is expected to be of long-continued or indefinite duration;
  - (b) Substantially impedes the person's ability to live independently;
  - (c) Is such that the person's ability to live independently could be improved by more suitable housing conditions.

I, ____________________________, here by certify that ___________________________ should be
Provider Tenant/Applicant
considered disabled in accordance with definition number(s) ________________ listed above.

_______________________________________________________
Name & Title of Provider

__________________
Date

_______________________________________ _____________________
Signature of Provider Phone

### TENANT/APPLICANT RELEASE:

I, ________________________________, hereby authorize the release of the requested information.
Tenant/Applicant

_______________________________________ ___________________
Signature Tenant/Applicant Date

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