Greenburgh Housing Authority
9 Maple Street
White Plains, NY 10603
914-946-2110/2111
914-946-6240 (fax)

VERIFICATION OF DISABILITY

Name: _____

Address: _____

Social Security Number: _____

I authorize the release of any information pertaining to this request and would appreciate your completing and returning the certification to the Housing Authority

_____ _____
Applicant Signature **Date**

This person has applied for housing under a federally assisted or New York State assisted program. To determine eligibility, we are required to verify that he/she is disabled as defined by H.U.D and N.Y.H.C.R.

We ask for your cooperation in providing the following information and return it in the self-addressed stamped envelope to:

Greenburgh Housing Authority
9 Maple Street
White Plains, NY 10603
914-946-2110(p) 914-946-6240 (f)
ATTN: HOUSING DEPARTMENT

Your prompt return in providing the following information and returning it will ensure timely processing of the application for assistance.

The applicant has consented to this release of information as shown above.

(To be completed by a physician)

Basis for Claiming Disability:

1. **Has an inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairments which can be expected to result in death, or which has lasted or can be expected to last for a period of not less than 12 months, or in the case of an individual who has attained the age of 55 and is blind and unable by reason of such blindness to engage in substantial gainful activity requiring skills or ability comparable to those of any gainful activity in which he/she has previously engaged with some regularity and over a substantial period of time.**

2. **A person that has a severe chronic disability that:**
   a) **Is attributable to a mental or physical impairment or combination of mental and physical impairments;**
   b) **Is manifested before the person attains age 22;**
   c) **Is likely to continue indefinitely;**
   d) **Results in substantial functional limitation in three or more of the following areas of major life activity;**
      1. **Self-care,**
      2. **Receptive and expressive language,**
      3. **Learning,**
      4. **Mobility ,**
      5. **Self-direction,**
      6. **Capacity for independent living, and**
      7. **Economic self-sufficiency**
   e) **Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are lifelong or extended duration and are individually planned and coordinated.**

3. **Is a person with a physical or mental impairment that (a) is expected to be of a long continued and indefinite duration, (b) substantially impedes his/her ability to live independently, (c) is of such nature that such disability could be improved by more suitable housing conditions**

CERTIFICATION OF DISABILITY:

Applicant ___is ____ is not disabled according to HUD/NYHCR definition

Applicable definition(s) from above _____ 1. ____2. _____3.

Please describe

_____

_____

Estimated length of disability period _____

Name of Person Certifying (Print): _____
Title: _____
Agency, Facility or Institution: _____
License Number: _____
Address: _____
Telephone: _____

I understand that the information obtained by the housing authority will be kept completely confidential.
I understand that false statements or information are punishable under federal and state law.