
HALS CoC Funded Housing Programs
Verification of Disability
Authorization to Release Information

Continuum of Care Applicant: _____

I hereby authorize the release of the information requested below to the HALS CoC Funded Housing Program for the purpose of determining my eligibility for the Continuum of Care Housing Program.

CoC Applicant's Signature _____ Date _____
_____, has applied for housing through the HALS CoC Funded Housing Program. The Department of Housing and Urban Development's regulations governing the Continuum of Care Program requires verification of disability as a condition of participation in the program.

This release authorizes you to provide information regarding the physical/mental condition on the above applicant as follows:

1. Does the applicant have a diagnosis of Schizophrenia (DSM V 295.90, 295.40, 295.70, 295.80), Major Affective disorders (DSM V 296.33 and 296.34), Bipolar disorders (DSM V 296.43, 296.44, 296.53, 296.54, 296.40, 296.7, and 296.89), Delusional disorder (DSM V 297.1), Psychotic disorder (DSM V 298.8 and 298.9), Schizotypal Personality disorder (DSM V 301.22), and Borderline Personality disorder (DSM V 301.83), Post Traumatic Stress disorder (DSM V 309.81)
Yes:_____ No: _____ Diagnosis and DSM V Code: _____

2. Has the applicant had the disability for two years or longer?
Yes: _____ No: _____ Date of Disability: _____

3. Is the disability expected to be of long- continued and indefinite duration?
Yes:_____ No: _____

4. Would the nature of the applicant's disability be improved by more suitable housing conditions? Yes: _____ No: _____

Physician's Name: _____
Street Address: _____
City:_____ State: _____ Zip Code: _____

| _____ | _____ | _____ |
|---|---|---|
| Signature of Physician, Psychiatrist or Licensed Professional | Phone Number | Date Completed |