Guide to Home Stretch Disability Verification

Instructions: Use this information as a guide when documenting disability for a Home Stretch referral. Include appropriate disability verification to enable matching to specific housing opportunities.

According to HUD guidelines, a person shall be considered to have a disabling condition if such a person has a diagnosable:

- Substance use disorder; AND/OR
- Serious mental illness; AND/OR
- Development disability (as defined in Section 102 of the Developmental Disabilities Assistance Bill of Rights Act of 2000, (42 U.S.C. 15002); AND/OR
- Post-traumatic stress disorder (PTSD); AND/OR
- Cognitive impairments resulting from brain injury; AND/OR
- Chronic physical illness or disability (e.g. HIV/AIDS)

And that condition meets all of the criteria below:

- Is expected to be of long-continued and indefinite duration; AND
- Substantially impedes the person's ability to live independently; AND
- Is of such a nature that the ability to live independently could be improved by more suitable housing conditions.

There are specific housing opportunities with set-asides or preferences for people with the following health conditions: HIV/AIDS, serious mental illness, developmental disabilities, and substance use conditions. Please have a licensed health care professional complete the **Home Stretch Disability Verification** to be considered for these specific housing opportunities.

If a licensed health care professional CANNOT complete the disability verification, then disability can also be verified by providing one of the documents listed below. However, it is strongly recommended that the **Home Stretch Disability Verification** be completed if possible.

Disability can also be verified by providing one of the documents listed below:

- Written verification of disability from the Social Security Administration, OR

- Copy of a disability check (e.g., Social Security Disability Insurance check or Veteran's Disability Compensation)

Home Stretch Disability Verification

To Be Completed By A Licensed Health Care Professional

This verification will help prioritize homeless and disabled individuals for permanent supportive housing opportunities in Alameda County.

This Disability Verification Form is for:

Patient Name: _____

Patient Date of Birth: _____

Clinician Contact Information:

Organization Name (if applicable): _____

Address: _____

Phone #: _____

E-mail: _____

I am a credentialed and licensed health care professional trained to perform diagnostic and functional assessments of patients. Within my scope of practice, I have determined that the patient named above has the following diagnosable condition(s) that are: 1) expected to be of long-continued and indefinite duration; AND 2) substantially impedes the individual's ability to live independently; AND 3) The condition could be improved by more suitable housing conditions. (check ALL that apply):

- ☐ Substance use disorder**
- ☐ Serious mental illness, including severe Post Traumatic Stress Disorder (as defined in the DSM and is severe in degree and persistent in duration; is NOT a substance use disorder, developmental disorder, or acquired traumatic brain injury)**
- ☐ Developmental disability (as defined in Section 102 of the Development Disabilities Assistance Bill of Rights Act of 2000, {42 U.S.C. 15002})**
- ☐ Cognitive impairments resulting from brain injury**
- ☐ Chronic physical illness or disability*
- ☐ HIV infection or AIDS*

***Acceptable Credentials for Medical Conditions:** *MD* (Medical Doctor), *NP* (Nurse Practitioner)
****Acceptable Credentials for Mental Health & Substance Use Conditions:** *MD* (Medical Doctor), *NP* (Nurse Practitioner), *PsyD/ PhD* (Psychologist), *LCSW* (Licensed Clinical Social Worker), MFT/*LMFT* (Marriage and Family Therapist), *LPCC* (Licensed Professional Clinical Counselor)

My signature below indicates my verification of the above information for this patient.

Intern Name, if applicable (printed): _____

Signature: _____ Date: _____

Licensed Staff Name (printed): _____

Signature: _____ Date: _____

Professional License Type: _____ License #: _____