If client does not claim to have a disabling condition, STOP and submit packet. If disabling condition cannot be verified today, please remove verification and send in when completed. Please submit packet immediately.

Verification of Disability

INSTRUCTIONS: This form may be filled out and signed only by a person who is licensed by the State of Missouri to make one of the diagnoses listed below. The agency must maintain appropriate documentation related to the diagnosis. Please indicate your professional licensure by checking a box below, and provide your license number.

- ☐ **Advanced Practice Registered Nurse**
- ☐ **Licensed Clinical Social Worker**
- ☐ **Licensed Professional Counselor**
- ☐ **Physician**
- ☐ **Psychiatrist**
- ☐ **Psychologist**

License number (*required*): ______________________

Applicant Name: ______________________

- ☐ The Applicant has been diagnosed with **a serious mental illness.**
- ☐ The Applicant has been diagnosed with **both a serious mental illness** and **a chronic alcohol or drug use disorder.**
- ☐ The Applicant has **a chronic alcohol use disorder and/or a chronic drug use disorder.**
- ☐ The Applicant has **a severe and chronic developmental disability** that:
  1. Is attributable to a mental or physical impairment or combination of mental and physical impairments;
  2. Manifested before the individual attained the age of 22;
  3. Is likely to continue indefinitely;
  4. Results in substantial functional limitations in three or more of the following areas of major life activity (*please check three or more of the following*):
     - ☐ Self-care
     - ☐ Receptive and expressive language
     - ☐ Learning
     - ☐ Mobility
     - ☐ Self-direction
     - ☐ Capacity for independent living
     - ☐ Economic self-sufficiency; and
  5. Reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated.
- ☐ The Applicant has **a diagnosis of HIV and/or AIDS.**
- ☐ The Applicant has **a physical disability.**

I have personally made the diagnosis specified above. The above individual has a disability that is expected to be of long-continued and indefinite duration; is expected to substantially impede this person's ability to live independently; and is of such a nature that it could be improved by more suitable housing conditions.

______________________	______________________	______ / ______ / ______
Print Name	**Signature**	**Date**