

### Applicant Instructions:

This form must be completed for the head of household, co-head, or spouse of the household who is claiming a disability, if they do not receive Social Security, SSI, or state benefits. This information is necessary to determine eligibility for certain disability-related deductions available under housing assistance programs administered by the Grand Rapids Housing Commission (GRHC) under the U.S. Department of Housing and Urban Development (HUD).

Please read and sign the authorization statement allowing your physician to release the requested information to GRHC on your behalf. Then, fill out your medical provider's contact information. Once signed, GRHC will forward the form to your physician or medical provider to complete the remaining sections. Consult page 3 of this document for HUD's definitions of a disabled person.

## Household Member Information

<b>Last Name:</b>		<b>First Name:</b>		<b>Middle Name:</b>	
<b>Date of Birth:</b>		<b>SSN #:</b>		<b>Head of Household:</b> <i>(if different)</i>	
<b>Address:</b>					
<b>City:</b>		<b>State:</b>		<b>Zip Code:</b>	

## Medical Provider Contact Information

<b>Last Name:</b>		<b>First Name:</b>		<b>Title</b> <i>(MD/DO/NP/PA):</i>	
<b>Street Address:</b>		<b>City:</b>		<b>State:</b>	<b>ZIP Code:</b>
<b>Phone:</b>		<b>Fax:</b>		<b>Email</b> <i>(if available):</i>	

## Applicant Release

I hereby authorize the release of the requested information to the Grand Rapids Housing Commission.

_____ <i>Applicant/Resident Signature:</i>	_____ <i>Printed Name:</i>	_____ <i>Date (MM/DD/YYYY)</i>
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**Applicant: Do Not Continue!**

*Page 2 for Physician/Medical Provider Only*



REASONABLE ACCOMMODATION NOTICE: IF YOU REQUIRE ASSISTANCE OR A REASONABLE ACCOMMODATION TO COMPLETE THIS FORM DUE TO A DISABILITY, PLEASE CONTACT OUR OFFICE AT 616-235-2600. WE ARE COMMITTED TO ENSURING EQUAL ACCESS TO OUR SERVICES AND WILL PROVIDE APPROPRIATE ASSISTANCE TO HELP YOU COMPLETE THIS FORM.

**Physician/Medical Provider Instructions:**

The patient (applicant) named above has authorized you to complete this form to assist the Grand Rapids Housing Commission (GRHC) in determining eligibility for disability-related deductions for HUD housing assistance programs.

Please review the definitions on page 3 and indicate whether the applicant meets any of HUD’s definitions of a disabled person in the fields below. If so, specify the applicable definition number(s).

**Physician/Medical Provider Certification**

I hereby certify, based on my professional medical opinion and knowledge of the applicant named above’s condition, that they:

1. \_\_\_ **Should be considered disabled** according to the definitions on the following page  
*If selected, please indicate the applicable definition number(s): \_\_\_\_\_*
2. \_\_\_ **Should not be considered disabled** according to the definitions on the following page.
3. \_\_\_ **Should not be considered disabled** because their disability is based *solely* on a drug or alcohol dependence (no other disability that meets the definitions below).

**Notice of Federal Penalties for False Statements (18 U.S.C. § 1001)**

Federal law (18 U.S.C. § 1001) prohibits giving false or misleading information to the U.S. Government, including for housing programs administered by the Grand Rapids Housing Commission (GRHC) and the Department of Housing and Urban Development (HUD). This includes lying, hiding important facts, or submitting documents with false information. Violations may result in fines and up to 5 years in prison (or up to 8 years for certain serious offenses).

_____ <i>Physician/Medical Provider Signature:</i>	_____ <i>Printed Name:</i>	_____ <i>Date (MM/DD/YYYY)</i>
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**Return Instructions**

**IMPORTANT:** This form must be returned directly by the physician or medical provider. For regulatory compliance, GRHC cannot accept forms returned by the applicant/patient.

Preferred Method	Email
Please scan and email the completed, signed form to:	<a href="mailto:ic@grhousing.org" style="color: blue; text-decoration: underline;">ic@grhousing.org</a>
Alternate Method	Fax or Mail
If email is <u>not possible</u> , you may return the form to:	<b>Grand Rapids Housing Commission</b> <b>Attn: _____</b> <b>1420 Fuller Avenue, S.E.</b> <b>Grand Rapids, MI 49507</b> Phone: (616) 235-2600 Fax: (616) 235-2660

## Definitions of Disabled Person

**Note:** For low-income housing, individuals whose disability is based solely on drug or alcohol dependence are not considered disabled. However, they may still be considered “individuals with handicaps” for reasonable accommodations and accessibility.

### 1. Has a disability, as defined in 42 U.S.C. 423, which means:

- (A) Inability to engage in any substantial gainful activity due to a medically determinable physical or mental impairment that is expected to result in death or has lasted, or is expected to last, for a continuous period of at least 12 months; *or*
- (B) For individuals aged 55 or older who are blind, this means being unable, due to blindness, to engage in substantial gainful activity that requires skills or abilities comparable to those used in past work performed regularly over a substantial period of time.

### 2. Has a developmental disability, as defined in Section 102(8) of the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C. 15002(8)), meaning a severe chronic disability that:

- (A) is attributable to a mental and/or physical impairment;
- (B) Is manifested before the person attains age 22;
- (C) Is likely to continue indefinitely;
- (D) Causes significant limitations in at least three of the following areas: independent living, self-care, communication, learning, mobility, self-direction, or economic self-sufficiency; *and*
- (E) Reflects a person's need for a combination of special, interdisciplinary, or generic care, treatment, or services that are of extended or lifelong duration and individually planned and coordinated.

### 3. Has a physical, mental, or emotional impairment that:

- (A) Is expected to be of long-continued or indefinite duration;
- (B) Substantially impedes his or her ability to live independently; *and*
- (C) Is of a nature that the ability to live independently could be improved by more suitable housing conditions.

### 4. Has acquired immunodeficiency syndrome (AIDS) or any condition arising from the etiologic agent of AIDS (i.e., Human Immunodeficiency Virus [HIV]).