



Providing Homes, Creating Community, Changing Lives

Disability Verification

Boulder Housing Partners | 4800 N. Broadway, Boulder, CO 80304 | p: 720-564-4610 | www.boulderhousing.org

Tell Us About Your Doctor/Physician

Doctor or Clinic Name	Doctor or Clinic Phone #
Clinic/Medical Institution Address	Doctor or Clinic Fax # or Email
Applicant/Resident Name	Head of Household Name
Applicant/Resident Social Security #	Applicant/Resident Date of Birth (MM/DD/YYYY)

Consent to Release Information:
My signature below authorizes verification of my medical information.

Applicant/Resident Signature

Date

STAFF USE ONLY

The above Applicant/Resident is applying to/participating in a housing program that requires verification of disability. The individual has signed a release above giving you permission to supply us with information requested. The information provided will remain confidential. Please return the completed form to the address, fax, or email below.

«User Name»

BHP Representative Name

«User Job Title»

BHP Representative Title

«User Fax No»

BHP Representative Fax

4800 N Broadway, Boulder, CO 80304

BHP Representative Address

«User Email Address»

BHP Representative Email



Hearing Assistance
1-800-659-3656



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Property Management Department

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This section to be completed by qualified medical staff as defined in U.S. Code: Title 42, 1437a

The determination of disability status, as defined by Congress, must be based on a professional medical evaluation. Certification of authorized medical personnel as defined above

(Please check only one box)

1. [] I find this individual has a physical or mental impairment that limits one or more major life functions that has lasted or is expected to last for a continuous period of not less than 12 months.

-OR-

2. [] I find this individual does not have a physical or mental impairment that substantially limits one or more major life functions and is expected to last, or has lasted, less than 12 months.

Warning: Section 1001 of Title 18 of the U.S. Code makes it a criminal offense to make willful, false statements of misrepresentation to any Department or Agency of the U.S. as to any matter within its jurisdiction.

Eligible evaluators include: State Licensed Medical Professional and Social Security Administration Representative

Signature of Evaluator/Diagnostician

Title

Date

Print Name of Evaluator/Diagnostician

Telephone #

Please return the completed form to the address, fax or email listed on page 1.



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