



Dear Applicant:

Attached is an application for the Permanent Supportive Housing Program (PSH) in Jefferson Parish. **PLEASE NOTE:** This is not immediate housing. You are applying for a waitlist.

**What is PSH?**

PSH are special rental apartments that come with supports for people who have difficulty living successfully in the community and may become homeless or institutionalized without the supports. These housing supports include things like reminders to pay the rent and keep your apartment clean as well as help arranging medical appointments or other support services. Only people with substantial, long-term disabilities who need these types of supports are eligible for PSH.

**PSH Requirements**

To be eligible for PSH, your household must (1) have a member who has a substantial, long-term disability, (2) need the housing supports offered by PSH Program, and (3) have household income within the HUD established income limits, preferably extremely low income.

**How do I apply if I think I am eligible?**

Complete the attached application and sign page 10. You will be required to verify (a) the income of all household members (b) that you or a member of the household has a substantial, long-term disability, and (c) the household is in need of supports. Applications without required supporting documents **will not** be processed. Below is a list of the required documentation that must be submitted with your signed application:

<b>Check Box</b>	<b>Required Verification Documents That Must Be Attached to Application</b>
<input type="checkbox"/>	Birth Certificate(s) for all household members
<input type="checkbox"/>	Social Security Card(s) for all household members
<input type="checkbox"/>	Picture Identification of all household members over 18
<input type="checkbox"/>	Proof of income and assets for all household members; award letters, check stubs, etc.
<input type="checkbox"/>	Proof of disability; award letter or letter from doctor stating disability
<input type="checkbox"/>	“In Need of PSH” Verification Form completed only by a service provider
<input type="checkbox"/>	“Hurricane Displacee” Verification Form (if applicable)

**Where do I send my completed application and supporting documentation?**

**JPHSA – Division of Community Support  
5001 Westbank Expressway, Suite B  
Marrero, LA 70072**



**This application is only good beginning March 18, 2011**

**PERMANENT SUPPORTIVE HOUSING APPLICATION**  
***JEFFERSON PARISH HUMAN SERVICES AUTHORITY***

Please complete the entire application as fully as possible. The application will not be considered complete unless all of the questions that have an asterisk \* are completed and the application is signed. **Attach the required documents and return them with the signed application to Jefferson Parish Human Services Authority at the address at the end of this application. If you have any questions, please call Christian Jones or Catherine Yockey (504) 349-0010.**

**APPLICANT (Head of Household) Information**

*Please Print Clearly*

\_\_\_\_\_  
*\*First Name* *MI* *\*Last*

\_\_\_\_\_  
*\*Street*

\_\_\_\_\_  
*\*City* *\*State* *Zip Code*

\_\_\_\_\_  
*Social Security Number* *Birth Date*

It is important that we can get in touch with you. Please provide as many phone numbers as possible.

Home: (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_

Email: \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_

Pager: (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_ Mobile/Cell (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_

**Optional: You may provide an alternative contact in the event that your contact information changes and we cannot locate you.**

\_\_\_\_\_  
*First Name* *MI* *Last*

Relationship to you \_\_\_\_\_

\_\_\_\_\_  
*Street*

\_\_\_\_\_  
*City* *State* *Zip Code*

Home: (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_

Email: \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_

Pager: (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_ Mobile/Cell (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_

**DEMOGRAPHIC INFORMATION**

**1. Race (Voluntary – Please select one or more):**

- White
- American Indian/Alaskan Native
- Native Hawaiian/Other Pacific Islander
- Asian and White
- American Indian/Alaskan Native and Black
- Black or African American
- Asian
- American Indian/Alaskan Native and White
- Black/African American and White
- Other

**2. Ethnicity (Voluntary - Please select “yes” or “no” for Hispanic Origin.)**

**Hispanic:**  Yes  No

**3. Citizenship (please check) Are you a citizen of the United States?**

Yes  No

*(Some noncitizens are eligible for this program)*

**4. Gender (please check):**  Male  Female

**5. Veteran (please check)**  Yes  No

**6. Near Elderly - Defined as a head of household 55 to 61 years of age**

*(Please check)*  Yes  No

**7. Elderly - Defined as a head of household 62 years of age or older**

*(Please check)*  Yes  No

**8. Aging Out Youth: You are aging out of the state Foster Care system**

*(please check)*  Yes  No

**9. Accessibility:** Does a member of your household require the special design features of a particular unit? If so, please check yes and which accommodation(s) you need.

- Yes  No
- Wheelchair  Parking Space  Grab Bars & Handrails  No Steps  Few Steps
- Hearing Disability  Visual Disability  Roll-In Shower
- Other, please explain:

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**10. Pets:** Do you have household pets?

*(please check)*  Yes  No

**PERMANENT SUPPORTIVE HOUSING ELIGIBILITY**

You must meet **all three PSH requirements** to be eligible for the program. Please check yes or no in response to each of the three questions below. Please provide explanations as requested.

1. \* **Does a member of your household have a substantial, long-term disability** including but not limited to serious mental illness, addictive disorder, developmental disability, physical or sensory disability, chronic illness such as HIV or a frail elder?  
Yes      No

*In order to help you access any needed supports it is helpful for us to know what type of disability you have. This information is **voluntary and confidential** and will **NOT** impact your eligibility.*

- Serious Mental Illness;
- Addictive Disorder, i.e., individuals in treatment/recovery from substance abuse disorder;
- Developmental Disability, i.e., mental retardation, autism, or other disability acquired before the age of 22;
- Physical, sensory, or cognitive disability occurring after the age of 22;
- Disability caused by chronic illness (e.g., people with HIV/AIDS who are no longer able to work); or
- Age-related disability (i.e., “frail elderly).
- Other \_\_\_\_\_

2. \* **Do you or a member of your** household need the Supportive Services provided by the PSH program to allow you and/or your family to live in the community and not become evicted or homeless?  
Yes      No

**On the lines below, please explain why your household needs support and describe the type of housing support needed:**

*Examples might include: someone making sure you keep your apartment clean, pay your bills or go to medical or other appointments. The supports may be services you already receive or services you would like to receive. The need for subsidized rent or financial assistance alone does not qualify an applicant for the PSH Program.*

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- Check this box if you have continued your explanation on a separate sheet of paper.

3. \***Is your annual household income Very Low?**    Yes      No

**The maximum annual income you can have for your household size cannot be higher than the amounts listed below:**

Household Size*	1 person	2 persons	3 persons	4 persons	5 persons	6 persons
Jefferson Parish income limits	\$21,700	\$24,800	\$27,900	\$30,950	\$33,450	\$35,950

\* includes babies and children in the household

\*Please estimate the total **annual** income for everyone who will live in the household:

\$ \_\_\_\_\_

There is an income worksheet on page 5 that you need to complete.

## PREFERENCE POINTS

Depending upon your current housing circumstances, you may qualify for a **preference** under this program. Please review the housing situations described below and check any boxes that describe your personal situation. **Documentation must be submitted.**

- Hurricane Displacee:** You had to move because of hurricanes Rita and/or Katrina. This might be because your housing was destroyed or because your rent was no longer affordable after the hurricane. ***If yes, complete and sign page 11.*** **Please note:** Displacee status for this program **does not** apply to those displaced by hurricanes Ike or Gustav.
  
- Homeless:** Are you in one of the following situations? Check the one that applies:
  - Living in a car, parks, sidewalks, abandoned buildings, on the street or similar;
  - Living in an emergency shelter;
  - Living previously on the street but are now living in a transitional housing program;
  - Homeless but living for no more than 30 days in a hospital or other institution.
  
- At Risk of Homelessness or Living in Transitional Housing for the Homeless:** Is your household in one of the following situations, don't have anywhere else to live and not enough funds to pay for housing? Check the one that applies:
  - Household is being evicted or foreclosed within 30 days by a private landlord?
  - Household is being discharged within 30 days from an institution, such as a mental health or substance abuse treatment facility, in which you lived for more than 30 days?
  - Household is fleeing a domestic violence housing situation?
  - Household is living in temporary housing situations such as in motels, hotels, and FEMA trailers or in an untenable doubled up arrangements?
  - Household is exiting, mental health or developmental disability facilities, nursing homes, residential addiction treatment programs, or hospitals?
  - Household includes youth aging out of foster care who qualifies for PSH?
  - Household is living in transitional housing but did not originally come from emergency shelter or a place not meant for human habitation
  
- Inappropriately Institutionalized:** A household member lives in a nursing home, ICF-DD, psychiatric facility, or other residential treatment facility, because they have a disability but would prefer to live in the community. Check which one applies:
  - Nursing home
  - ICF-DD
  - Psychiatric facility
  - Other residential treatment facility: \_\_\_\_\_
  
- At Risk of Institutionalization:** A member of the household is at risk of institutionalization if you are faced with placement in a nursing home, Intermediate Care Facility/Developmental Disabilities (ICF/DD) or long-term (more than 14 days) psychiatric hospital because (check the one that applies):
  - A caregiver is no longer able or willing to continue providing care;
  - A caregiver has passed away and no other caregiver is available;
  - You can't stay in your temporary housing arrangement any longer;
  - Your household faces some other family crisis with no caregiver support available;
  - Someone's health or disability status impacts the member's ability to live independently

**HOUSEHOLD INFORMATION**

List all persons who will be living in the unit and their relationship to the Head of Household. Complete the information in the chart for all members of the household.

First Name	Last Name	Relation to Head	Birth Date	Age	Sex	Social Security #
		Head				

Does a member of the household require 24-hour care by a caretaker or live-in aide?

Yes       No

**SUMMARY OF HOUSEHOLD INCOME AND ASSET SOURCES**

Please put the **monthly** amount of income for each household member in the boxes as appropriate.

	Head	Member 2	Member 3	Member 4	Member 5	Member 6	Member 7
<b>Employment</b>							
<b>Child Support</b>							
<b>SSI</b>							
<b>SSA</b>							
<b>Pension Income</b>							
<b>Public Assistance</b>							
<b>Self Employment</b>							
<b>Other</b>							
<b>Other</b>							
<b>TOTAL</b>							

**Employment:** For each job, please list place of employment:

\_\_\_\_\_

**Other:** Please list any other types of income:

\_\_\_\_\_

\_\_\_\_\_

**Documentation:** Please provide documentation of all income listed such as pay stubs, copy of SSI check, etc.

**ASSETS**

1.) Do you own any real estate? Yes No  
 If yes, please provide the address:

\_\_\_\_\_

2.) Have you disposed of any assets within the last two years? Yes No  
 If yes, describe the asset and the amount disposed of:

\_\_\_\_\_

3.) Do you have a checking and/or savings account? Yes No  
 If yes, list name of financial institution and account number:  
 Name of Bank \_\_\_\_\_ Account # \_\_\_\_\_

**List below the assets of everyone to live in the unit; include all bank accounts, stocks and bonds, trusts, real estate, etc.**

*DO NOT include clothing, furniture or cars. Use additional paper if necessary*

	Head	Member 2	Member 3	Member 4	Member 5	Member 6	Member 7
Checking Account							
Savings Account							
Stocks, Bonds							
Trust							
IRA, Other Pension							
Other							
Other							

**EXPENSES**

1. Do you pay for child care for a member of the household age 12 or younger that allows you or another adult to work, look for work or go to school?

Check one: Yes No

**If so, please list the amount of child care paid and for whom:**

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2. If the head, co-head or spouse is disabled, do you have **out-of-pocket medical expenses** not covered by insurance?

Check one: Yes No

**If so, please list the type and amount of medical expenses:**

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3. Do you have any out-of-pocket expenses (i.e. care attendant, electric wheelchair, etc.) for a disabled member of the household that allows someone to go to work?

Check one: Yes No

**If so, please list the type and amount of disability expenses:**

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**OTHER HOUSEHOLD INFORMATION**

**Criminal Record:** The answers to the following questions about you and your household member's criminal records **WILL NOT** impact eligibility for PSH. Providing us accurate and complete information will help us make referrals of your household to landlords more successful.

Have you or any member of your household who will live in the unit have a criminal record?

Check one: Yes No

If you checked "yes", please provide a detailed explanation of the charges and the years these charges took place:

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**PSH UNITS IN JEFFERSON PARISH**

In Jefferson Parish, there is an East Bank wait list and a West Bank wait list. Check yes or no next to East Bank or West Bank indicating whether or not you would be interested in residing in that area. Also check the unit size you **require**. Do **NOT** check “yes” for any locations where you would not consider living. **PLEASE NOTE:** This is not immediate housing. You are applying for a waitlist.

Location	Yes	No	Unit Size Needed			
			1 Bdrm	2 Bdrm	3 Bdrm	4 Bdrm
East Bank of Jefferson Parish	<input type="checkbox"/>	<input type="checkbox"/>				
West Bank of Jefferson Parish	<input type="checkbox"/>	<input type="checkbox"/>				

**COMMUNICATION**

Do you have a case worker or other professional that we may contact to discuss the status of your application? If so, please list their name below. If so, you will be asked to sign a separate consent form allowing us to contact this person.

Name \_\_\_\_\_

Agency \_\_\_\_\_

Phone or e-mail: \_\_\_\_\_

**If you are not being referred by an agency or service provider, please provide us with the following information:**

How did you hear about the Louisiana Permanent Supportive Housing Program?  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Where did you obtain the application?  
 \_\_\_\_\_

**CERTIFICATION**

**Privacy Act Statement:** The information on this form is being collected on behalf of the Department of Housing and Urban Development (HUD) to help determine an applicant’s eligibility. It will be used to provide the basis for managing the program covered by this form, for protecting the Government’s financial interest and for verifying the accuracy of the information furnished.

**Penalty for false or fraudulent statements:** U.S.C. Title 18, Sec 1001, provides that “Whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme, or device a material fact, or makes any false, fictitious or fraudulent statements or representations, or makes or uses any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry, shall be fined not more than \$10,000 or imprisoned not more than five years, or both.”

**Applicant(s) Statement:** I/we understand that false statements or information are punishable under federal law.

\_\_\_\_\_  
*\*Applicant Signature*

\_\_\_\_\_  
*\*Date*

The completed application and **copies** of all supporting documentation should be mailed to:

**JPHSA – Division of Community Support  
5001 Westbank Expressway, Suite B  
Marrero, LA 70072**

**For Office Use ONLY**

**Date and Time Application Received:**

**Received by:**  Catherine Yockey     Christian Jones     Other

**Signature:** \_\_\_\_\_

**Applicant Referred by:** \_\_\_\_\_

**Tenant ID #:**



Jefferson Parish  
Human Services Authority

**Hurricane Displacee Verification Form**

Date: \_\_\_\_\_

What was your address at the time of Hurricane Katrina or Rita?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Landlord Name \_\_\_\_\_

Phone Number \_\_\_\_\_

Why were you unable to return to that address after Hurricane Katrina or Rita?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**CERTIFICATION**

**Privacy Act Statement:** The information on this form is being collected on behalf of the Department of Housing and Urban Development (HUD) to help determine an applicant’s eligibility. It will be used to provide the basis for managing the program covered by this form, for protecting the Government’s financial interest and for verifying the accuracy of the information furnished.

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**Applicant(s) Statement:** I/we understand that false statements or information are punishable under federal law.

\_\_\_\_\_  
*Applicant Signature*

\_\_\_\_\_  
*Date*

**Authorization to Release or Obtain Information  
For Permanent Supportive Housing Program Eligibility  
(including paper, oral and electronic information)**

Name:	Request Date:
Mailing Address:	Date of Birth:
City/State/Zip:	Medicaid ID# or Social Security #:

**I authorize: Jefferson Parish Human Services Authority**  
5001 Westbank Expressway Suite B Marrero, LA 70072 (504) 349-0010

- To Release Information TO**  
**AND**  
 **To Obtain Information FROM**

Name: Quadel Housing Services
Mailing Address: 2700 Lake Villa Drive, Suite 100 Metairie, LA 70002
Relationship: Subsidy Administrator Telephone Number: (504) 535-2888

The **Purpose of this Authorization** is indicated in the box below:

- Eligibility Determination

**I authorize the release of the following information (describe information being requested):**

Information pertaining to disability, income, supports needed and housing status as well as PSH application

**This authorization shall expire on \_\_\_\_\_ (date or event) and  
is needed for the period beginning \_\_\_\_\_ and ending \_\_\_\_\_**

I understand that if I do not specify an expiration date, this authorization will expire six (6) months from the date on which it was signed. I acknowledge that I have read both pages 1 and 2 of this form.

<b>Signature of Individual or Personal Representative Authorized by Law</b>	Date
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Signature of Witness (If signed with an 'X' or mark)	Date
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**For JPHSA Use When Requesting Records**

*I am authorized to receive this disclosure. Documentation on the above Personal Representative has been obtained.*

Signature and Title of Agency Representative	Date
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The In Need of PSH form documents which services Housing Support Team staff will need to provide to a PSH program participant. It can be filled out by the applicant, a referring agency, or a treatment professional. This form must be completed in order for the LLA to process the application, and will also be used by the Housing Support Team to assess the needs of the participant once they have been accepted.

### **Completing the In Need of PSH form**

Applicant Name & Application Date	At the top of the form, the applicant (or someone assisting them) should fill out the applicant's name and the date the form is completed.
Name of Individual In Need of Supports	If the person needing PSH services is not the applicant, such as a child or spouse, provide the name of the person who will receive the services.
Disability(s)	List the disabilities that the person In Need of PSH has.

### **Primary Limitations**

Some of the things PSH participants need help with are serious enough to put them at risk of eviction.

If the participant needs help from a Housing Support Team in any **one** of these areas **to avoid losing their apartment**, they can be considered In Need of PSH.

#### **Because of their disability, the participant:**

Medications	takes the wrong amount, can't remember to take their medications regularly, or refuses to take medications.
Finances	can't keep track of their money without help, and has trouble paying their rent or bills on time (or doesn't pay them at all).
Housekeeping	can't keep their apartment clean enough to satisfy the landlord.
Self care	can't clean themselves, use the toilet, or move around without the help of someone else.

### **Additional Limitations**

A PSH participant may need help with several things that are less serious than the ones listed above, but when taken together mean that the participant will have trouble taking care of themselves or their apartment.

If the participant needs help from a Housing Support Team in any **three** of these areas **to avoid losing their apartment**, they can be considered In Need of PSH.

#### **Because of their disability, the participant:**

Mobility	has a hard time walking or getting around.
Motor skills	can't do many everyday things because they can't use their arms or hands well.
Transportation	can't make their own transportation arrangements, such as taking a bus or calling a friend or taxi.
Communication	can't speak or write well enough to be understood, or doesn't respond to questions or follow conversations.

**Because of their disability, the participant:**

Behavior	doesn't act appropriately around other people.
Interaction	is afraid of other people or is aggressive towards other people without reason.
Shopping	is unable to do all of their shopping without help from another person.
Food Preparation	can't make meals more complicated than cereal, microwave meals, or toast without help from another person.
Laundry	can't wash some or all of their clothes without help from someone else.
Comprehension	can't understand questions or instructions, or needs to be shown how to do something many times.
Problem Solving	can't figure out how to solve basic problems without help from someone else.
Safety	doesn't understand things that may be dangerous or what to do about them, such as opening doors to strangers, knowing when to call 911, or knowing to get out of the apartment if there is a fire.
Resources	doesn't know how to use resources even after they've been explained, such as knowing how to catch a bus.

**Additional Comments**

If there are other things the participant needs help with that aren't shown above, feel free to note them in this section. This will help the person approving the application understand how serious the applicant's needs are, and will also help the Housing Support Team design a care plan.

**Certification**

Signing this form means that everything on it is as complete and correct as possible. This document should show what kinds of help the participant needs in order to live in and keep their apartment.

Signature of Applicant or Representative	The applicant's signature, or the signature of the person helping them.
Print Name	The readable printed name of the signature above.
Signature of Referring Staff	The signature of the person who referred the applicant to the PSH program, such as a State Office or local housing agency employee, if there is one.
Signature of Treatment Professional	The signature of a doctor or medical professional if one is willing to sign.

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Applicant Name

Application Date

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Name of Individual in Need of Supports (if different from above)

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Disability(s)

This form must be completed and signed to certify that the applicant to the Permanent Supportive Housing program, or someone in their household, has a need for the tenancy supports provided in the program. Certification that PSH supports are needed is one of the three program eligibility requirements. The other two are (1) having a disability, and (2) being extremely low-income.

To determine if the individual's impairment(s) result in a substantial impediment to housing, please indicate the serious limitations in the following categories of major life functions that result from the applicant's impairment(s). **Serious limitations in the following areas means that the individual frequently requires assistance from others in order to successfully obtain and/or maintain housing.**

**PRIMARY LIMITATIONS**

Check all that apply. Any **one** of the below means that the applicant is in need of Supportive Housing.

- Medications  
*Unable to manage medications (correct dosages at correct time)*
- Finances  
*Unable to independently manage day-to-day finances and purchases*
- Housekeeping  
*Unable to maintain an acceptable level of cleanliness*
- Self Care  
*Unable to complete basic activities of daily living without assistance, including bathing, dressing, using toilet, transferring (move in and out of bed or chair), and/or have continence. May require long term assistance, such as from a personal care attendant or disability-related case manager.*

**ADDITIONAL LIMITATIONS**

Check all that apply. Any **three** of the below means that the applicant is in need of Supportive Housing.

**MOBILITY**

- Mobility  
*Impaired ability to walk/ambulate*
- Motor skills  
*Unable to perform daily tasks due to decreased motor skills*
- Transportation  
*Unable to arrange own travel (private or public transportation)*

**BASIC COMMUNICATION**

- Communication  
*Expressive primary mode of communication is unintelligible to non-family members or general public or responses/comments are irrelevant to the subject or question being considered.*
- Behavior  
*Unable to correctly interpret and respond appropriately to social cues and monitor or adjust one's own behavior appropriately*
- Interaction *Unable to interact with others without demonstrating fear, anxiety or aggression*

**SECONDARY SELF CARE**

- Shopping  
*Unable to take care of all shopping needs independently*
- Food Preparation  
*Unable to plan, prepare and serve adequate meals independently*
- Laundry  
*Unable to launder all items (with or without assistance)*

***ADDITIONAL LIMITATIONS (continued)***

**COMPREHENSION**

- Comprehension  
*Unable to receive meaningful communication and independently understand written or verbal instructions, and/or requires repeated demonstration*
- Problem Solving  
*Unable to independently plan and manage or solve problems*
- Safety  
*Unable to safely complete daily tasks without putting self and/or others at risk of harm, unaware of surroundings or exhibits behavior that puts self or others at risk*
- Resources  
*Unable to use resources independently once demonstrated and/or linked*

Additional Comments:

*I certify that the foregoing information is true and accurate to the best of my knowledge.*

\_\_\_\_\_  
**Signature of Applicant or Representative**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
Signature of Referring Staff (if applicable)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Treatment Professional (if available)

\_\_\_\_\_  
Date

*PSH Program Use Only*

\_\_\_\_\_  
Signature of Local Lead Agency Staff

\_\_\_\_\_  
Verification Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Agency

**DATE:**

**CONSUMER NAME:**

**SS NUMBER:**

**DOB:**

**DIAGNOSIS:**

**This letter is to confirm that the above-named consumer has been diagnosed with the disability(s) specified above. I can verify that this disability:**

- **Is expected to be of long-continued and indefinite duration;**
- **Substantially impedes his or her ability to live independently;**
- **Could be improved by more suitable housing conditions, and;**
- **That this individual requires the types of tenancy supports provided by the PSH Program in order to live successfully in the community and maintain a stable tenancy.**

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**Signature**

**Date**

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**Name (Please Print)**

**Phone Number**

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**Agency**

***NOTE: This form must be signed by a MD, DO, LCPC, LCSW, LMSW, APRN-BC, NP***