



Disability Verification Attachment B

INSTRUCTIONS: This form identifies the Applicant's primary disability that is of long and continuing duration and impedes his or her ability to work and live independently. If the Applicant has multiple disabilities, please choose only the one that most substantially impedes his or her ability to work and live independently.

This form may be filled out only by a person who is licensed by the State of Georgia 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
- Medical Doctor
- Psychiatrist
- Psychologist

APPLICANT'S NAME: _____ DOB: _____ SS# _____

- The Applicant has been diagnosed with a **serious and persistent mental illness (SPMI)**.
- The Applicant has been diagnosed with **both a serious and persistent mental illness (SPMI) and a chronic alcohol or drug abuse disorder (CSA)**.
- The Applicant has a **chronic alcohol abuse disorder and/or a chronic drug abuse disorder (CSA)**.
- The Applicant has an **intellectual/developmental disability (I/DD)** 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 **traumatic brain injury (TBI)**.

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 of Person Verifying Disability) (Signature of Person Verifying Disability)

➤ License number (required): _____ Date: _____

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 United States or to any matter within its jurisdiction.



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