TAKE THIS TO YOUR DOCTOR!

New Horizon Property Management, Inc.
P. O. Box 240044, Milwaukee, WI 53224
Phone: (414) 355-3605 Fax: (414) 797-4326

EQUAL HOUSING OPPORTUNITY

2026 DISABILITY VERIFICATION FORM

(For use with Section 202/8, 202 PAC, 202 PRAC, and 811 PRAC Housing Developments)

Note to Applicant/Tenant: You do not have to sign this form if either the requesting organization or the organization supplying the information is left blank. Please note that HUD does not require the disclosure of social security numbers on this form. The person noted above has applied for housing assistance under a program of the Department of Housing and Urban Development (HUD). HUD requires the housing owner to verify all information that is used in determining this person's eligibility or level of benefits.

DIRECTIONS:
The 1st page of this form should be completed, signed, and dated by the applicant. The second page of this form must be completed by a doctor to verify the applicant's physical disability. Both pages must be returned to our office. For questions, please call (414)355-3605.

RETURN THIS FORM DIRECTLY TO OUR OFFICE
DO NOT GIVE IT TO THE APPLICANT/TENANT
SCAN AND EMAIL: **rentals@newhorizonwi.com**
FAX: **(414) 797-4326**

Date: _____

MEDICAL PROVIDER NAME & ADDRESS:

_____

_____

_____

_____

APPLICANT/TENANT FULL NAME & ADDRESS:

_____

_____

_____

_____

I hereby authorize the release of the requested information. Information obtained under this consent is limited to information that is no older than 12 months. There are circumstances that would require the owner to verify information that is up to 5 years old, which would be authorized by me on a separate consent attached to a copy of this statement.

Applicant / Tenant Signature	Date

Penalties For Misusing This Consent:
Title 18, Section 1001 of the U.S. Code states that a person is guilty of a felony for knowingly and willingly making false or fraudulent statements to any department of the United States Government. HUD and any owner (or any employee of HUD or the owner) may be subject to penalties for unauthorized disclosures or improper uses of information collected based on the consent form. Use of the information collected based on this verification form is restricted to the purposes cited above. Any person who knowingly or willingly requests, obtains or discloses any information under false pretenses concerning an applicant or participant may be subject to a misdemeanor and fined not more than $5,000. Any applicant or participant affected by negligent disclosure of information may bring civil action for damages and seek other relief, as may be appropriate, against the officer or employee of HUD or the owner responsible for the unauthorized disclosure or improper use. Penalty provisions for misusing the social security number are contained in the Social Security Act at **208 (a) (6), (7) and (8). ** Violation of these provisions are cited as violations of 42 U.S.C. Section **408 (a) (6), (7) and (8). **

Full name of disabled individual: _____

Circle the response that most accurately describes the person whose information you are verifying.

Yes	No	This person has a physical impairment that is expected to be of long-continued and indefinite duration, substantially impedes his or her ability to live independently, and is of a nature that such ability could be improved by more suitable housing conditions.
Yes	No	This person has a developmental disability, as defined in Section 102(7) of the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C. 6001(8)), (i.e., a person with a severe chronic disability) that: a. Is attributable to a mental or physical impairment or combination of mental and physical impairments; b. Is manifested before the person attains age 22; c. Is likely to continue indefinitely; d. Results in substantial functional limitation in three or more of the following areas of major life activity; 1) Self-care, 2) Receptive and expressive language, 3) Learning, 4) Mobility, 5) Self-direction, 6) Capacity for independent living, and 7) Economic self-sufficiency; and e. Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment or other services that are of lifelong or extended duration and are individually planned and coordinated.
Yes	No	This person has a chronic mental illness, i.e., he or she has a severe and persistent mental or emotional impairment that seriously limits his or her ability to live independently, and whose impairment could be improved by more suitable housing conditions.
Yes	No	This person's sole impairment is alcoholism or drug addiction.

Printed Name of Medical Professional	Professional Title
Signature of Medical Professional	Date Signed
Name of Firm, Organization or Medical Facility	
Address (Street, City, State, Zip)	
Phone Number	Fax

PLEASE RETURN BOTH PAGES!