



DISABILITY/HANDICAP VERIFICATION

Client Name	Social Security Number
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PERMISSION FOR RELEASE OF INFORMATION:

I, _____ (client) . Authorize you to furnish the

information requested below to:

Perspectives, Inc.
3381 Gorham Avenue
St. Louis Park, MN 55426

for the purpose of determining my eligibility for participation in a subsidized housing program. I understand that the information is confidential and will be used only in determining program eligibility and that I have the right to rescind this authorization in writing at any time, but that to do so may affect my eligibility for program participation.

Signature

Date

Thank you for your prompt attention to this matter.

Certification of Disability

A person who is disabled to the extent of being unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment, which has lasted or can be expected to last for a continuous period of not less than twelve (12) months.

In my opinion, the above named person DOES DOES NOT have a disability as defined above.

AND

A person who has an impairment, which

1. Is expected to be of long-continued and indefinite duration
2. Substantially impedes ability to live independently
3. Is of such a nature that such ability could be improved by more suitable housing conditions.

In my opinion, the above named person DOES DOES NOT have a disability as defined.

(NOTE: without the above statements being answered, the application cannot be accepted.)

The information requested below **MUST** be completed entirely for the application to be valid.)

Date Disability/Handicap began: _____

Evaluator/Diagnostician Name: _____

Address: _____

Signature: _____ Title: _____

Date: _____ Phone: _____