Certification of Disability

Dear Physician / Qualified Health Personnel:

The applicant listed below has claimed eligibility for a federally funded housing program due to a disability. A professional licensed by the State of California to diagnose and treat the condition must certify the claim. For the purpose of this program, a disabled person is one who is diagnosed with one or more of the following conditions: substance use disorder, serious mental illness, developmental disability (as defined in Section 102 of the Developmental Disabilities Assistance Bill of Rights Act of 2000 (42 U.S.C. 15002), post-traumatic stress disorder, cognitive impairments resulting from brain injury, or chronic physical illness or disability. This disability must be expected to be of a long-continued and indefinite duration, substantially impede his/her ability to live independently, and is of such a nature that the disability could improve under more suitable housing conditions. This disability may also be developmental.

To certify disability, please provide the information requested below.

Thank you for your prompt reply.

Applicant Name:

Applicant/Tenant Release Authorization:
I hereby authorize release to the City of Pasadena Housing Department the specific information requested below.

Signature of Applicant: ______________________ Date: __________

Certification of Disability:
In my opinion, as a professional licensed by the State of California to diagnose and treat such conditions the applicant as the following disability(s) (check all that apply):

- ☐ Substance use disorder
- ☐ Serious mental illness
- ☐ Developmental disability (as defined in section 102 of the Developmental Disabilities Assistance Bill of Rights Act of 2000 (42 U.S.C. 15002))
- ☐ Post-traumatic stress disorder
- ☐ Cognitive impairments resulting from brain injury
- ☐ Chronic physical illness or disability

Medical Certification by Professional:

Signature of Licensed Professional: ______________________ Print Name: __________

Professional Title: ______________________ Telephone: __________

License Number: __________ Name of Medical Group: __________

Address: ______________________ Date: __________