Guide to Home Stretch Disability Verification

Instructions: Use this information as a guide when documenting disability for a Home Stretch referral. Include appropriate disability verification to enable matching to specific housing opportunities.

According to HUD guidelines, a person shall be considered to have a disabling condition if such a person has a diagnosable:

- Substance use disorder; AND/OR
- Serious mental illness; AND/OR
- Development disability (as defined in Section 102 of the Developmental Disabilities Assistance Bill of Rights Act of 2000, (42 U.S.C. 15002); AND/OR
- Post-traumatic stress disorder (PTSD); AND/OR
- Cognitive impairments resulting from brain injury; AND/OR
- Chronic physical illness or disability (e.g. HIV/AIDS)

And that condition meets all of the criteria below:

- Is expected to be of long-continued and indefinite duration; AND
- Substantially impedes the person’s ability to live independently; AND
- Is of such a nature that the ability to live independently could be improved by more suitable housing conditions.

There are specific housing opportunities with set-asides or preferences for people with the following health conditions: HIV/AIDS, serious mental illness, developmental disabilities, and substance use conditions. Please have a licensed health care professional complete the Home Stretch Disability Verification to be considered for these specific housing opportunities.

If a licensed health care professional CANNOT complete the disability verification, then disability can also be verified by providing one of the documents listed below. However, it is strongly recommended that the Home Stretch Disability Verification be completed if possible.

Disability can also be verified by providing one of the documents listed below:

- Written verification of disability from the Social Security Administration, OR
- Copy of a disability check (e.g., Social Security Disability Insurance check or Veteran’s Disability Compensation)
Home Stretch Disability Verification

To Be Completed By A Licensed Health Care Professional

This verification will help prioritize homeless and disabled individuals for permanent supportive housing opportunities in Alameda County.

This Disability Verification Form is for:

Patient Name: ____________________________________________________________
Patient Date of Birth: ______________________________________________________

Clinician Contact Information:

Organization Name (if applicable): __________________________________________
Address: __________________________________________________________________
Phone #: __________________________________________________________________
E-mail: ____________________________________________________________________

I am a credentialed and licensed health care professional trained to perform diagnostic and functional assessments of patients. Within my scope of practice, I have determined that the patient named above has the following diagnosable condition(s) that are: 1) expected to be of long-continued and indefinite duration; AND 2) substantially impedes the individual’s ability to live independently; AND 3) The condition could be improved by more suitable housing conditions. (check ALL that apply):

☐ Substance use disorder**
☐ Serious mental illness, including severe Post Traumatic Stress Disorder (as defined in the DSM and is severe in degree and persistent in duration; is NOT a substance use disorder, developmental disorder, or acquired traumatic brain injury)**
☐ Cognitive impairments resulting from brain injury**
☐ Chronic physical illness or disability*
☐ HIV infection or AIDS*

*Acceptable Credentials for Medical Conditions: MD (Medical Doctor), NP (Nurse Practitioner)
**Acceptable Credentials for Mental Health & Substance Use Conditions: MD (Medical Doctor), NP (Nurse Practitioner), PsyD/PhD (Psychologist), LCSW (Licensed Clinical Social Worker), MFT/LMFT (Marriage and Family Therapist), LPCC (Licensed Professional Clinical Counselor)

My signature below indicates my verification of the above information for this patient.

Intern Name, if applicable (printed): __________________________________________
Signature: ___________________________ Date: _____________________________

Licensed Staff Name (printed): ____________________________________________
Signature: ___________________________ Date: _____________________________

Professional License Type: ___________________________ License #: _____________

Contact HOME STRETCH

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