

**LOUISVILLE METRO COMMUNITY SERVICES AND REVITALIZATION**

**Disability Certification Part 1**

**Applicant :** \_\_\_\_\_

**Social Security Number:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Person with disabilities** means a household composed of one or more persons, at least one of who is an adult who has a disability.

A person shall be considered to have a disability if such person has a physical, mental, developmental, or emotional impairment which is expected to be:

- (1) long-term and of indefinite duration;
- (2) substantially impedes his or her ability to live independently,
- (3) **and** is of such a nature that said disability could be improved by more suitable housing conditions.

The term AIDS “Acquired Immunodeficiency Syndrome and related diseases” means the disease of Acquired Immunodeficiency Syndrome or any conditions arising from the ecologic agent for Acquired Immunodeficiency Syndrome.

**Your signature below certifies that the above named applicant meets the three prong definition of disability as stated above.**

**This person is considered to have the disability/ties listed below:  
For more than one disability, please indicate what the primary and secondary disabilities are.**

- Diagnosis: A. Mental Illness \_\_\_\_\_ D. AIDS/Related \_\_\_\_\_ F. Other \_\_\_\_\_  
explain
- B. Alcohol Abuse \_\_\_\_\_
- C. Drug Abuse \_\_\_\_\_ E. Physical Disability \_\_\_\_\_

\_\_\_\_\_  
Physician’s Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Physician’s Name & Phone Number

Are there any recommendations of services for this client that may help them sustain permanent housing? \_\_\_\_\_

\_\_\_\_\_

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