DISABILITY VERIFICATION

Property Name: _____ **Unit:** _____

Applicant/Resident Name: _____

Name of Qualifying Household Member: _____

The above-referenced property rents units under programs administered by the Washington State Housing Finance Commission. Under these programs, the Owner has agreed to provide some of the units for persons with disabilities as defined below.

We are required to complete the verification process within certain time frames, and your prompt attention to this matter will be greatly appreciated.

"DISABILITY" means:

A physical or mental impairment that substantially limits one or more of the major life activities of an individual, such as not being able to care for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, or learning.

I certify that the above referenced applicant falls within this Disability definition.

I certify this information as the applicant's (please check the appropriate box):

- ☐ Physician
- ☐ Relative
- ☐ Social Worker
- ☐ Caregiver
- ☐ Other _____

_____ _____ _____

Signature Title Date

_____ _____

Print Name Phone #

** Site staff cannot complete this form.*