BILLERICA
HOUSING AUTHORITY

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Name of Physician________________________________

Physician's Address______________________________

____

Date________________________

PHYSICIAN'S VERIFICATION OF HANDICAPPED STATUS FOR STATE-AIDED ELDERLY/HANDICAPPED HOUSING

______________________________ ______________________________
Applicant's Name **Applicant's Control Number**

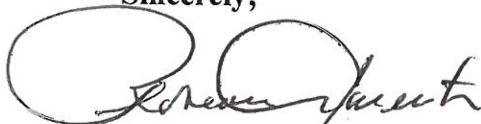
____

____
Applicant's Address

I hereby authorize release of the following information:______________________________
Applicant's Signature

The Housing Authority is required by state regulations to obtain a physician's certification documenting that an applicant has a qualifying physical or mental impairment in order to determine the applicant's eligibility for elderly/handicapped housing. The applicant has authorized above your release of the requested information. We would appreciate your prompt response to the questions on the reverse side of this letter. If you have questions, please contact our office. Thank you for your anticipated cooperation.

Sincerely,



Robert Correnti
Executive Director

THE FOLLOWING TO BE COMPLETED BY PHYSICIAN (OR OTHER PROFESSIONAL)

Note: an applicant's eligibility for Elderly/Handicapped Housing is contingent on the Authority being able to identify and understand whether the applicant has a qualifying impairment and how it affects his or her housing needs. Please be sure to complete this form legibly and in a manner that allows the Authority to meaningfully evaluate the applicant's eligibility.

1. Does the applicant have one or more physical or mental impairments, other than a history of alcohol or substance abuse, which substantially impede(s) his or her ability to live independently? Circle the appropriate answer.*

   Yes / No

   Comment:

   ____

   ____

   ____

2. If Yes to question 1 above, would suitable housing conditions improve the applicant's ability to live independently and, if so, what sort? Be specific.

   ____

   ____

   ____

3. If Yes to question 1 above, is the anticipated duration of the applicant's impairment(s) more than six (6) months? Circle the appropriate answer.

   Yes / No

   If the anticipated duration is indefinite so specify, and estimate the approximate duration to the best of your ability:

   ____

   ____

4. Other comment:

   ____

   ____

CERTIFICATION

I certify that the information provided above represents my professional judgment and is true and accurate to the best of my knowledge and belief.

____________________ Signature	________________ Date
____________________ Printed Name	________________ Telephone
____________________ Street	
____________________ City & State Zip	

____

*Note: an applicant that has a history of alcohol or substance abuse may still be eligible for Elderly/Handicapped Housing if the applicant has one or more qualifying physical or mental impairments in addition to the history of alcohol or substance abuse and is otherwise eligible and qualified for such housing.