BHA	**Applicant(s) Verification of Disability**	*Please complete and return to :* **Bethlehem Housing Authority** **Attn: Admissions** **645 Main Street** **Bethlehem, PA 18018**	Date Stamp (PHA office use only)

ONLY MEDICAL PERSONEL TO COMPLETE

Head of Household:	SS # : XXX – XX -
Patient's Name :	

BHA defines disability as the following:
A person with a disability, as defined under the federal civil rights laws is any person who:
• Has a physical or mental impairment that substantially limits one or more of the major life activities of an individual, or
• Has a record of such an impairment, or
• Is regarded as having such an impairment
The phrase "physical or mental impairment" includes, but is not limited to, the following: Any physiological disorder or condition, cosmetic disfigurement, and/or anatomical loss affecting one or more body systems.

Is the person **disabled** as per the definition listed? Is the disability expected to be of a long duration, or temporary?	☐ Yes ___ Long Term	☐ No ___Temp.

Does the disability require BHA to be aware of any special needs regarding their housing?		
☐ Yes	☐ No	**If yes please explain:**

Print Doctor's Name:	Phone Number:
Address:	
Doctor's Signature:	Date:

By signing this form I certify that the patient is a "qualified individual with a disability", and that the request is related to the disability and impairment that substantially limits one or more major life activities. I understand that any inaccurate or untruthful statements will be considered as fraud, and may lead to civil and/or criminal prosecution.