



**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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is the disability expected to be of a long duration, or temporary?	<input type="checkbox"/> Long Term	<input type="checkbox"/> Temp.
Does the disability require BHA to be aware of any special needs regarding their housing?		
<input type="checkbox"/> Yes	<input type="checkbox"/> 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.