

**Texas Department of Housing and Community Affairs
Housing Trust Fund**



CERTIFICATION OF DISABILITY

INSTRUCTIONS: Administrators of Housing Trust Fund (HTF) Programs must use this form to certify that a member of a household applying for HTF assistance has a disability. Name the person with disability and the head of household applying for HTF assistance. Attach a copy of an award letter for the Person with Disability OR have a licensed professional certify disability.

Contract Administrator Name: East Texas Council of Governments		TDHCA Contract #: 1001208
Address: 3800 Stone Rd. Kilgore, TX 75662		
Phone: (903) 984-8641 ext. 280	Fax: (903) 983-1440	Email: ben.carpenter@etcog.org
Name of Person with Disability:		
Current Address:		City, State and Zip:
Head of Household (receiving HTF Assistance):		
Relationship to Person with Disability:		
<input type="checkbox"/> self <input type="checkbox"/> spouse <input type="checkbox"/> dependent <input type="checkbox"/> other (please specify):		

A copy of the following award letter for the Person with Disability is on file with the Contract Administrator (check one):

- Current Supplemental Security Disability Income (SSDI) award letter
- FOR UNDER AGE 62 ONLY: Current Supplemental Security Income (SSI) award letter
- Other federal disability award letter (e.g. from the U.S. Department of Veterans Affairs)

If **EITHER** of the above documents can be provided, DO NOT COMPLETE the rest of this form. The Household will be considered to meet the definition of Person with Disability.

If **NEITHER** of the above documents can be provided, a licensed professional familiar with the condition of the Person with Disability must complete the rest of this form with authorization from the Person with Disability.

I, _____, authorize the licensed professional below to certify me as a Person with Disability for the purposes of eligibility for housing assistance.

Signature of Person with Disability or his/her Guardian

Date

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CERTIFICATION	
Name:	Title:
Contact Address:	City, State, Zip:
Telephone:	Email:
<p>I am a (check one):</p> <p><input type="checkbox"/> Medical Doctor (MD), Advanced Practice Nurse (APN) or Nurse Practitioner (NP)</p> <p><input type="checkbox"/> Licensed Professional Counselor (LPC) or Licensed Clinical Social Worker (LCSW)</p> <p><input type="checkbox"/> Licensed Chemical Dependency Counselor (LCDC)</p> <p><input type="checkbox"/> Other (please specify): _____ <i>(Requires TDHCA approval)</i></p> <p>Person with Disabilities – An Individual who has a disability that is a physical or mental impairment that substantially limits one or more major life activities (HTF Rule 10 TAC §51.2(51)).</p> <p>I certify that the above person is a Person with Disability as defined above.</p>	
_____ Signature of Professional Authorized to Certify	_____ Date
<p>WARNING: Title 18, Section 1001 of the U.S. Code states that a person is guilty of a felony for knowingly and willingly making false or fraudulent statements to any department of the United States Government.</p>	