

NAME & ADDRESS OF MEDICAL DOCTOR:		REQUESTING AGENCY:
		ACCESS, Inc.
		3630 Aviation Way
		Medford, OR 97504
Phone #:	Fax #:	Phone #: 541-779-6691 or Fax to 541-779-8886

DISABILITY/HANDICAPPED STATUS VERIFICATION for Applicant/Resident:

Name:	Social Security #:
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PERMISSION FOR RELEASE OF INFORMATION: Information obtained under this consent is limited to information no older than 12 months. There are circumstances which would require the owner to verify information that is up to 5 years old, which would be authorized by me on a separate consent attached to a copy of this consent.

I (the applicant) authorize the release of the information requested:

Applicant's Signature	Date

APPLICANT – DO NOT WRITE BELOW THIS LINE

Time is of the essence and we thank you for your cooperation. All information is confidential. Please return this form in the addressed, stamped envelope provided. If you have any questions, please feel free to contact ACCESS, Inc.

TO THE APPLICANT'S / RESIDENT'S MEDICAL DOCTOR: Please read the following description of Disability; Disability as defined in 42 U.S.C. 423, is the (a) Inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months; or (b) in the case of an individual who has attained the age of 55 and is blind, inability by reason of such blindness to engage in substantial gainful activity requiring skills or abilities comparable to those of any gainful activity in which he/she has previously engaged with some regularity and over a substantial period of time.

CERTIFICATION:

I hereby certify that the above named individual has a physical or mental disability as defined above and that this form is completed in response to a direct and explicit request of the patient.

[] Yes [] No

PREPARED BY:

Print Your Name:	Date:
Signature:	Telephone #:
Title (if applicable):	Organization:

WARNING: Section 1001 of Title 18 of the U.S. Code states that a person is guilty of a felony for knowingly and willingly making false statements to any department of the United States Government. HUD, the PHA and any owner or agent thereof, may be subject to penalties for unauthorized disclosures or improper use of information collected based on this consent form. Use of the information collected, based on this verification form, is restricted to the purposes cited above. Any person who knowingly requests, obtains or discloses any information under false pretenses concerning an applicant or participant may be subject to a misdemeanor and fined not more than \$5,000. Any applicant/participant affected by negligent disclosure of information may bring civil action for damages and seek other relief, as may be appropriate, against the officer or employee of HUD, the PHA, or the Owner responsible for the unauthorized disclosure or improper use of the above information.

ACCESS, Inc. does not discriminate on the basis of handicapped status in the admission, or access to, or treatment, or employment, in its federally assisted programs and activities.

