

TO: NAME & ADDRESS OF AGENCY		FROM: REQUESTING AGENCY	
		ACCESS, Inc.	
		3630 Aviation Way	
		Medford, OR 97501	
Phone #:	Fax #:	Phone #: 541-779-6691	Fax #: 541-779-8886

AGENCY PSYCHIATRIC DISABILITY VERIFICATION & REFERRAL FOR:

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 agree to continue receiving case management with the above agency for the time that I am residing at Woodrow Pines. I understand that if I break involvement with the above agency that my tenancy may be terminated.

Applicant Signature	Date
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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 and stamped envelope provided. If you have any questions, please feel free to contact ACCESS, Inc.

TO THE APPLICANT'S / RESIDENT'S QUALIFIED MENTAL HEALTH TECHNICIAN:

Please review the definition below and indicate whether or not the applicant meets the definition of having a psychiatric disability.

A person meets the definition of having a Psychiatric Disability if; they have been diagnosed with a serious mental illness which: (1) Is expected to be of a long, continued and indefinite duration; (2) Substantially impedes his or her ability to live independently; (3) or is of such a nature that such ability could be improved by more suitable housing conditions.

CERTIFICATION:

As the assigned clinician, I am acknowledging that the above mentioned person has a documented psychiatric disability that is in accordance with Social Security or State General Assistance Program requirements, and is currently enrolled in case management.

[] 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.

The policy of ACCESS, Inc. is one of equal opportunity and non-discrimination in compliance with all Civil Rights legislation (1964, 1968, 1988) Section 504 of the Rehabilitation Act of 1973 (if applicable) and Affirmative Fair Housing Marketing requirements. No applicant/tenant will be denied on the basis of race, color, religion, sex, familial status, handicap status or national origin.