SPECIAL NEEDS VERIFICATION

TO:

_____

_____

_____

FROM:

_____

_____

_____

RE:

_____
Name

_____
Social Security Number

Thank you for your prompt response. All information is confidential.
Please contact _____
at ( ) _____ if you have any questions.

PERMISSION FOR RELEASE OF INFORMATION

You do not have to sign this form if either the requesting organization or the organization supplying the information is left blank.

Release: I hereby authorize the release of the requested information. Information obtained under this consent is limited to information that is 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.

_____ _____
Signature Date

To the Applicant's/Tenant's Medical Doctor:

Please review the statements below and indicate whether or not the conditions apply to the above-named applicant.

A. Has a serious and persistent mental illness as defined in Minnesota Statutes Section 245.462, Subdivision 20, paragraph (c). Yes ☐ No ☐

B. Has a developmental disability as defined in United States Code, title 42, Section 6001, Paragraph (5), as amended. Yes ☐ No ☐

C. Has been assessed as drug dependent as defined in Minnesota Statutes Section 254A.02, Subdivision 5, and is receiving or will receive care and treatment services provided by an approved treatment program as defined in Minnesota Statutes Section 254A.02, Subdivision 2. Yes ☐ No ☐

D. Has a brain injury as defined in Minnesota Statutes Section 256B.093, Subdivision 4, paragraph (a). Yes ☐ No ☐

E. Has a permanent physical disability that substantially limits one or more major life activities. Yes ☐ No ☐

If you are unable to complete this form, please indicate reason: _____

_____

I certify that this form is completed in response to a direct and explicit request of the patient.

_____ _____
Medical Provider's Name (Print or type) Signature of Medical Provider

( ) _____ _____
Telephone Number Date

PENALTIES FOR MISUSING THIS CONTENT: 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. HUD and any owner (or any employee of HUD or the owner) may be subject to penalties for unauthorized disclosures or improper uses of information collected based on the consent form. Use of the information collected based on this verification form is restricted to the purposes cited above. Any person who knowingly or willingly 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 or 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 or the owner responsible for the unauthorized disclosure or improper use. Penalty provisions for misusing the social security number are contained in the Social Security act at 208 (a) (6), (7) and (8). Violations of these provisions are cited as violations of 42 USC 408 (a), (6), (7) and (8).