Staff Observation of Disability Under COVID-19 Waiver – CoC Program

# Background:

On March 31, 2020, the Department of Housing and Urban Development issued a memorandum regarding “Availability of Waivers of Community Planning and Development (CPD) Grant Program and Consolidated Plan Requirements to Prevent the Spread of COVID-19 and Mitigate Economic Impacts Caused by COVID-19.” The memorandum made available a temporary waiver of certain disability documentation requirements for CoC-funded housing. [RECIPIENT NAME] notified the HUD San Francisco Regional Office of our intent to implement this waiver on [DATE].

# Instructions:

This form can be used in place of third-party documentation of disability for applicants with an enrollment date on or after May 31, 2020, for as long as public health restrictions to prevent the spread of COVID-19 are an obstacle to obtaining third-party documentation of disability. It must be used in accordance with the CoC’s Quality Assurance Standards and [RECIPIENT/SUBRECIPIENT NAME]’s written policies.

This form may only be used if third party documentation cannot be obtained. To use this form, follow the instructions below:

1. Program staff must complete the “Justification” section of this form.
2. Program staff complete the “Staff Observation” section of this form. Staff certification must be based on observation of the client or other reliable information.
3. This form must be added to the applicant’s client file.

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# Justification:

Applicant Name (print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Enrollment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(Note: This form can only be used for applicants enrolled between March 31, 2020 and September 30, 2020.)*

Describe your efforts to obtain 3rd-party documentation of the applicant’s disability from a licensed professional and explain why it was not possible to obtain it. The reasons must be related to preventing the spread of COVID-19 or to public health restrictions currently in place to prevent the spread of COVID-19:

Name of Program Staff (please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Program Staff: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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# Staff Observation of Disability:

I certify that, in my professional opinion based on my observation or on other reliable information, I believe that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ has a disability that meets the definition indicated below:

 *(Applicant Name)*

|  |  |  |
| --- | --- | --- |
| 1. | A physical, mental, or emotional condition that:1. Will be of long-continuing or indefinite duration;
2. Impedes their ability to live independently; and
3. Support from a housing program will help them be able to live independently.
 | Yes ☐ No ☐ |
| 2. | A developmental disability. Developmental disability is defined as a severe, chronic disability of an individual that is:1. Attributable to a mental or physical impairment or combination of mental and physical impairments;
2. Is manifested before the individual attains age 22;
3. Is likely to continue indefinitely;
4. Results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency; and,
5. Reflects the individual’s need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated.

*Note: An individual from birth to age 9, inclusive, who has a substantial developmental delay or specific congenital or acquired condition may be considered to have a developmental disability without meeting three or more of the criteria above if the individual, without services and supports, has a high probability of meeting those criteria later in life.* | Yes ☐ No ☐ |
| 3. | Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) | Yes ☐ No ☐ |

Staff Name (please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_