**DATE**

I, hereby, certify that **INSERT NAME, (DOB)** has been diagnosed with at least one of the following:

* A substance use disorder, serious mental illness, post-traumatic stress disorder, cognitive impairments resulting from a brain injury, or chronic physical illness or disability
* A developmental disability, as defined in section 102 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15002); OR
* Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV).

And that condition meets all of the criteria below:

* Is expected to be of long-continued and indefinite duration; AND
* Substantially impedes the person’s ability to live independently; AND
* Is of such a nature that the ability to live independently could be improved by more suitable housing conditions.

By signing below, I hereby certify that I am qualified professional who is licensed by the State of California to diagnose and treat the condition, verify their disability, and that it meets all the criteria outlined above.

Providers Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ License Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

License Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Agency Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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