



OPPORTUNITIES
for Williamson & Burnet Counties

Self-Identification of Disability

Complete this statement for each member in the household that is disabled and not receiving Social Security benefits. If receiving Social Security benefits, do not complete this form.

Applicant's Name _____

Name of Person with Disability _____

Relationship of Person with Disability to Applicant _____

Person with Disability is any individual who is:

- ❖ A handicapped individual as defined in §7(9) of the Rehabilitation Act of 1973;
- ❖ Under a disability as defined in §1614(a)(3)(A) or §223(d)(1) of the Social Security Act or in §102(7) of the Developmental Disabilities Services and Facilities Construction Act; or
- ❖ Receiving benefits under 38 U.S.C. Chapter 11 or 15.

I hereby authorize the above mentioned individual, for the purpose of confirming eligibility as a Person with Disability, is in accordance with the above-stated definition of Person with Disability.

I certify that the above information is true and correct to the best of my knowledge and belief. If any part is false, my participation in this agency's program may be terminated, and I may be subject to legal action. I also understand that the information in this application will be held in strict confidence within the agency and is accessible to me during normal business hours.

Signature of Person with Disability or His/Her Guardian

Date

