



**TRAVIS COUNTY HEALTH AND HUMAN SERVICES DEPARTMENT**  
Family Support Services Division

---

**Disability Verification Form**

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

Applicant: \_\_\_\_\_ CABA App #: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Is this adult unable to work or obtain or maintain employment due to a health condition?

Yes

No

If yes, how long is this disabling condition expected to last? \_\_\_\_\_

Does this minor have a disability due to a health condition?

Yes

No

If yes, how long is this disabling condition expected to last? \_\_\_\_\_

**PROVIDER INFORMATION:**

Licensed Health Professional/Physician:

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

Printed Provider Name: \_\_\_\_\_

Provider Address: \_\_\_\_\_

Provider Phone: \_\_\_\_\_

Return Form to: \_\_\_\_\_  
TCHHS, Family Support Services Assigned Caseworker