**Verification of Disability**

**Part I: Applicant Information**

Applicant Name: _____ Date: _____

Current Address: _____

**Part II: Person With Disabilities Information & Instructions**

Name of Household Member with Disabilities: _____

Last Four of Social Security Number: xxx-xx_____

The above-named individual is an applicant for, or a participant in, a federally funded program operated by _____ and in partnership with Tennessee Housing Development Agency and has stated they are permanently disabled. Disability must be verified to determine qualifying factors for Low Income Home Energy Assistance Program. Your prompt completion of this form is appreciated.

**PLEASE COMPLETE THE MEDICAL CERTIFICATION**

**Part III: Medical Certification of Need to Be Completed by Physician/Health Care Professional**

Disability Definition
Disability is defined as meeting one or more of the following criteria:

1. ☐ Substantial Gainful Activity Limitation
   - An inability to engage in any substantial gainful activity due to a medically determinable physical or mental impairment:
     - That is expected to result in death, or
     - Has lasted or is expected to last for a continuous period of not less than 12 months.
2. ☐ Severe Chronic Disability
   - A severe chronic disability that:
     - Is attributable to a mental or physical impairment, or a combination of impairments:
     - Is manifested before the individual attains age 22;
     - Is likely to continue indefinitely;
     - Results in substantial functional limitations in three or more of the following areas of major life activity:
     - Selfcare

- Self-direction
- Receptive and expressive language
- Learning
- Mobility
- Capacity for independent living
- Economic self sufficiency
- Reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services of lifelong or extended duration that are individually planned and coordinated.

3. ☐ Independent Living Impairment

- A physical or mental impairment that:
  - Is expected to be of long continued and indefinite duration;
  - Substantially impedes the person's ability to live independently;
  - Is of such a nature that the person's ability to live independently could be improved by more suitable housing conditions.

☐ None of the above

Name of Individual: _____

Date of Certification: _____

Printed Name of Certifying Professional: _____

Title/Professional: _____

Approved By Certifying Professional: _____

License Number: _____ State: _____ Phone Number: _____

Approved By Physician/Health Care Professional: _____Date: _____