Verification of Disability Form

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 SS#: xxx-xx- _____

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

PART III: MEDICAL CERTIFICATE OF NEED – 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:
     - (a) Self-care
     - (b) Receptive and expressive language
     - (c) Learning
     - (d) Mobility
     - (e) Self-direction
     - (f) Capacity for independent living
     - (g) 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.

CERTIFICATION

I, the undersigned **physician/health care professional**, do hereby certify that the individual listed below meets the definition of disability as outlined above.

Please check all applicable subsection(s):

☐ 1. Substantial Gainful Activity Limitation
☐ 2. Severe Chronic Disability
☐ 3. Independent Living Impairment
☐ 4. None of the above

Name of Individual: _____
Date of Certification: _____

Printed Name of Certifying Professional: _____
Title/Profession: _____
Signature: _____
License Number: _____ State: ____
Phone Number: _____

SIGNATURE OF PHYSICIAN/HEALTH CARE PROFESSIONAL:

_____ _____

SIGNATURE **DATE**

Note: Title 18, Section 1001 of the United States Code, states that a person who knowingly and willingly makes false statements to any department or agency of the United States or the Department of Health and Human Services as conducted by the LIHEAP Program through the State of Tennessee.