

App Key Number: _____

Disability Medical Statement

I, _____ (name of doctor or nurse practitioner), hereby certify that my patient, _____, has a medical disability that prevents him or her from engaging in any substantial, gainful employment. This condition has lasted or can be expected to last for a continuous period of twelve (12) consecutive months or longer, or can be expected to result in death.

Signature of Doctor or Nurse Practitioner

Date

Phone Number

Mailing Address of Medical Facility

I, _____, am currently applying for or am appealing a previous denial of benefits with the Social Security Administration related to a disability which has lasted or can be expected to last for a continuous period of twelve (12) consecutive months or longer, or can be expected to result in death. I am attaching a copy of proof of my application for or appeal of denial of such benefits. I understand that if I do not have an active application or appeal for these benefits, I may not qualify as a person with a disability for Energy Assistance Program or Low Income Home Water Assistance Program eligibility determination.

Signature of Household Member

Date

Agency Representative Signature

Date