Energy Assistance Programs

# PERMANENT DISABILITY VERIFICATION

Applicant Name: _____ Applicant Phone: _____

Applicant Address: _____

Patient Name: _____ Date of Birth: _____

The person listed above would like to be recognized as permanently disabled for Energy Assistance Programs. An applicant's determination of permanent disability does not guarantee eligibility or receipt of energy assistance benefits.

The Energy Assistance Programs need assurance from a licensed physician, medical practitioner or psychologist that this person is permanently disabled according to the program definition below. Please confirm if the person listed above fits the following definition:

## DEFINITION OF PERMANENTLY DISABLED

Persons who are unable to engage in any substantial paid activity by reason of any documented medically determinable physical or mental impairment that can be expected to last for twelve (12) continuous months or longer (or, in case of a child under the age of eighteen (18), if he/she suffers from any medically determinable physical or mental impairment of comparable severity). A statement of disability benefits may be considered proof of disability for an applicant.

☐ The person named above **meets** the definition of Permanently Disabled as written above.

☐ The person named above **does not meet** the definition of Permanently Disabled as written above.

## PHYSICIAN / MEDICAL PROFESSIONAL AUTHORIZATION

**Please stamp this form with your medical office address or other stamp to ensure authenticity.**

_____
Name of medical office

_____
Phone number of medical office

_____
Name of physician/psychologist

_____
Signature of physician/psychologist

Thank you for helping us to help this person.

## RELEASE OF CONFIDENTIAL INFORMATION

I (we) authorize the above individuals or agencies to exchange information about my disability status with the Energy Assistance intake screening office _____.

_____ _____ _____
PATIENT: Print Name PATIENT: Sign Name Date