ihcda
Indiana Housing & Community Development Authority

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, _____, hereby certify that 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**