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Date

## **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 , 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 the purposes of Energy Assistance Program eligibility determination. **Signature of Household Member** Date

**Agency Representative Signature**