HUM-403
REV. 9/94

STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES

CONNECTICUT ENERGY ASSISTANCE PROGRAM
CERTIFICATION OF DISABILITY

TO THE APPLICANT:

PLEASE FILL OUT, OR HAVE FILLED OUT BY THE APPROPRIATE PERSON, ALL BUT THE PHYSICIAN'S PART OF THIS FORM AND HAVE YOUR HOUSEHOLD'S PHYSICIAN FILL OUT AND SIGN HIS/HER PART CERTIFYING THAT YOU, OR THE APPROPRIATE MEMBER OF YOUR HOUSEHOLD, IS DISABLED. THE APPROPRIATE MEMBER OF YOUR HOUSEHOLD MUST, IF ABLE, SIGN THE STATEMENT CERTIFYING TO THE DISABILITY. RETURN THIS FORM TO THE INTAKE SITE, WHERE YOU APPLIED FOR ENERGY ASSISTANCE OR MAIL IT TO THE FOLLOWING ADDRESS:

_____
AGENCY'S NAME

_____
AGENCY'S ADDRESS (NO., STREET, TOWN, ZIP CODE)

PLEASE PRINT

NAME: _____
LAST *FIRST* *MIDDLE*

ADDRESS: _____
NUMBER AND STREET *CITY* *ZIP CODE*

TEL. #:(_____) – _____ SOC. SEC. #:___ ___ ___ – ___ ___ – ___ ___ ___ ___

DISABILITY CERTIFICATION

I AM A DISABLED PERSON. IN SUPPORT OF THIS STATEMENT I SUBMIT, BELOW, THE OPINION OF A PHYSICIAN AS REQUIRED, AND AFFIX MY SIGNATURE.

_____ _____
SIGNATURE OF DISABLED PERSON, LEGAL REPRESENTATIVE OR PARENT OF DISABLED MINOR CHILD — DATE

PHYSICIAN'S STATEMENT

I HAVE EXAMINED THE PERSON IDENTIFIED ABOVE AND IT IS MY MEDICAL OPINION THAT SHE/HE IS DISABLED.

_____ _____
SIGNATURE OF PHYSICIAN — DATE

PHYSICIAN'S STAMP

WHITE COPY — Agency; CANARY COPY — Applicant