



FAMILY INVESTMENT ADMINISTRATION VERIFICATION OF DISABILITY

Name: _____ Date of Birth: _____ Case ID Number: _____

Instructions: Check ONE box in SECTION 1 that applies to you. Sign and date this form at the end of SECTION 1. Complete SECTION 2 **only if requested by your caseworker**. Section 2 must be completed and signed by your Health Care Provider.

SECTION 1 – Customer to fill and sign

I am unable to work or participate in work activity because:

- I have a physical or mental disability.
- I am pregnant. My expected due date is: _____
- I am needed in the home to care for an ill or incapacitated household member

(Please answer the following questions).

Who are you caring for? _____

What is your relationship to them? I am their _____

Customer's Signature: _____ **Date:** _____

SECTION 2 – Health Care Provider to fill and sign

Name of Provider: _____

Medical Group: _____

Street Address/Suite: _____

City, State, Zip: _____

Provider's Phone Number: _____

Provider's License Number and state: _____

The named individual is unable to work or participate in a work activity until: (must indicate begin and end date – please do not use forever, indefinite, unknown for end date)

Begin Date: _____ End Date: _____

My signature verifies the person named above is unable to work or participate in a work activity for the period of time reported due to a disability.

Provider's Signature: _____ **Date:** _____

This form may be signed by any certified and licensed health care professional providing care to the named individual above.