ihcda
Indiana Housing & Community Development Authority

Disability Medical Statement

Application Key: _____

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, _____, 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.

_____ _____
Signature of Household Member **Date**

_____ _____
Agency Representative Signature **Date**