**W-1089**
(Rev. 10/25)

**State of Connecticut**
Department of Social Services

# CONNECTICUT ENERGY ASSISTANCE PROGRAM
# CERTIFICATION OF DISABILITY

Households applying for benefits through the Connecticut Energy Assistance Program (CEAP) are considered "vulnerable" and therefore eligible for increased benefits if at least one member of the household is blind or disabled. A person is considered disabled if they meet one or more of the following criteria:

1. **They have a physical or mental impairment that substantially limits one or more major life activities.**
   - Major life activities include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, working, and the operation of a major bodily function.
2. **They have a record of such an impairment.**
   - This means the person has a history of, or has been misclassified as having, such an impairment.
3. **They are regarded as having such an impairment.**
   - This applies if the person is treated by others as if they have an impairment, even if they do not have a disability that substantially limits a major life activity. This does not apply to impairments that are minor, or that have an actual or expected duration of 6 months or less.

If a disability is claimed but not accompanied by documentation of disability benefits, the applicant must provide verification from a physician, APRN, physician assistant, or psychiatrist. For blindness, an optometrist, ophthalmologist, or the Connecticut Board of Education and Services for the Blind may complete PART B or submit a certificate of blindness. ***Stamped signatures are permissible.***

## *PART A – COMPLETED BY APPLICANT*

**IDENTIFICATION OF APPLICANT** *(Please Print)*

**NAME OF PERSON WHO IS BLIND OR DISABLED** *(Last, First, Middle Initial)*

**DATE OF BIRTH** *(Required)* | **DAYTIME TELEPHONE NUMBER**

**ADDRESS** *(No. and Street)* *(City or Town)* *(State)* *(Zip Code)*

**MAILING ADDRESS** *(No. and Street)* *(City or Town)* *(State)* *(Zip Code)*

## *PART B – COMPLETED BY MEDICAL CERTIFIER*

**CERTIFIER'S NAME** *(Please print)*

CIRCLE ONE **P.A.** **PSYCHIATRIST** **PHYSICIAN** **APRN** **OPTOMETRIST** **OPHTHALMOLOGIST** **BESB**

**PROFESSIONAL LICENSE NUMBER** *(Required)*

**PROFESSIONAL LICENSING STATE** *(Required)*

**OFFICE ADDRESS** *(No. and Street)* *(City or Town)* *(State)* *(Zip Code)*

**OFFICE TELEPHONE NUMBER**

**MEDICAL CERTIFIER SIGNATURE**

I certify under the penalty of law that the person named in this application meets one or more of the qualifying criteria defined above. I understand that if I make a certification that I know or believe is not true with the intent to mislead the Department of Social Services or CEAP, I will be subject to prosecution under applicable law.

**SIGNATURE OF PHYSICIAN, PA, APRN, OPTOMETRIST, OPHTHALMOLOGIST, OR PSYCHIATRIST** | **DATE**

## *PART C – COMPLETED BY COMMUNITY ACTION AGENCY*

**CAA INFORMATION**

**NAME of CAA**

**NAME of CAA WORKER** | **DAYTIME TELEPHONE NUMBER**

**SIGNATURE**