Maryland
Department of
Human Services

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.