

I certify that my patient _____ is a severely disabled adult based on the following definition:

Definition of Severely Disabled Adult:

Persons are classified as having a severe disability if they: (a) used a wheel-chair or had used another special aid for six months or longer; (b) are unable to perform one or more "functional activities" or need assistance with an "ADL or IADL"; (c) are prevented from working at a job or doing housework; or (d) have a selected condition including autism, cerebral palsy, Alzheimer's disease, senility or dementia, or mental retardation. Also, persons who are [between the ages of 17 and 65] and who are covered by Medicare or who receive SSI are considered to have a severe disability.

Note: For purposes of this definition, the term "functional activities" includes seeing, hearing, having one's speech understood, lifting and carrying, walking up a flight of stairs, and walking. An ADL is an "activity of daily living" which includes getting around inside the home, getting in or out of bed or a chair, bathing, dressing, eating, and toileting. An IADL is an "instrumental activity of daily living" and includes going outside the home, keeping track of money or bills, preparing meals, doing light housework, and using the telephone.

Certified by

Print name of doctor

Signature of doctor

Date signed