



The Housing Authority of the County of Cook
EXEMPTION RELEASE FORM – PHYSICIAN / BLIND OR DISABLED

CLIENT NO. _____ UNIT NO. _____

NAME: _____

SOCIAL SECURITY No: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

TELEPHONE NO: _____ ALTERNATE NO: _____

****NOTICE****

Federal law requires adult residents of public housing to provide eight (8) hours of community service or to receive eight (8) hours of self-sufficiency training as a condition for retaining their tenancy.

You are requested to verify that the named resident qualifies for an exemption due to either blindness or disability, in accordance with the definition on the reverse side.

Definitions

Blind – An individual is blind when central visual acuity is 20/200 or less in the better eye with the use of a correcting lens. An eye, which is accompanied by a limitation in the fields of vision such that the widest diameter of the visual field subtends an angle no greater than 20 degrees, shall be considered for the purposes of this paragraph as having central visual acuity of 20/200 or less.

Disabled – An individual is disabled when (s)he is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or has lasted, or can be expected to last, for a continuous period of not less than 12 months.

NAME: _____

SOCIAL SECURITY No: _____ - _____ - _____

PHYSICIAN'S STATEMENT

I, (physician's name) _____, a [medical professional / ophthalmologist / optometrist] licensed to practice in the State of Illinois, certify that I examined the named resident and based on that examination conclude that the individual is

BLIND

DISABLED

as defined in the statutory definitions appearing above.

PHYSICIAN'S NAME: _____	LICENSE No: _____
SIGNATURE: _____	
FULL ADDRESS: _____ _____	
TELEPHONE No: _____	FAX No: _____

NOTE TO PHYSICIAN: Your cooperation in fighting fraud is requested. Attached to this certification should be a sheet of your physician prescription pad. We highly recommend that you boldly inscribe the word 'VOID' to prevent it's misuse. Thank you for your anticipated cooperation.

FOR OFFICE USE ONLY					
RECEIVED BY:		INITIALS:		DATE:	

WARNING: Making a false statement or providing false information is a criminal offense under federal and local law. This agency will prosecute violations of this notice.