Disability Certification Form

To establish eligibility to open and maintain a Maine ABLE Benefit Checking® account, the Beneficiary must either be receiving Social Security Income (SSI) or Social Security Disability Income (SSDI) or self-certify that they have a qualifying disability and have a written diagnosis from a licensed physician. The ABLE ME Program provides this form for Beneficiaries to obtain the required written diagnosis, if needed. This form is not required at Account Opening, however, the Beneficiary (or Authorized Representative) should retain it for their records.

I certify, to the best of my knowledge:

1 **Please choose A or B**

☐ **A.** The Beneficiary has a medically determinable physical or mental impairment that results in marked and severe functional limitations and that (i) can be expected to last for a continuous period of not less than 12 months or (ii) can be expected to result in death. I understand that "marked and severe functional limitations" means functional limitations that meet, medically equal, or functionally equal the severity of the listings in Listing of Impairments in appendix 1 of subpart P of 20 CFR part 404 (the "Listing"), but without regard to age. I further understand that the level of severity is determined by taking into account the effect of the individual's prescribed treatment.

☐ **B.** The Beneficiary is blind, meaning that they have central visual acuity of 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 as having a central visual acuity of 20/200 or less.

2 The Beneficiary's severe and marked medically determinable impairment or blindness occurred before their forty-sixth (46) birthday.

3 I am a "physician" meeting the criteria of section 1861(r)(1) of the Social Security Act.

As (Beneficiary's name)_____licensed health care provider, I am documenting the Beneficiary's primary diagnosis as required by the Stephen Beck, Jr., Achieving a Better Life Experience (ABLE) Act of 2014.

_____ _____

Primary Diagnosis (ICD-10) Date

_____

Provider Name

_____ _____

Provider Signature Provider Telephone Number