Certification of Chronic Limiting Condition

(for Senior Community Service Employment Program (SCSEP) Data Collection Validation)

Date of Assessment: _____

I, _____, have determined that _____,
(Doctor's name) *(Patient's name)*

is diagnosed with _____.
(Medical Condition)

This is a chronic condition which is attributable to mental or physical impairment, or a combination of mental and physical impairments. This condition is likely to continue indefinitely and results in substantial functional limitation in one or more of the following areas of major life activity. Please c*heck* ***all*** *that apply:*

- ❑ Self-care
- ❑ Receptive and expressive language
- ❑ Mobility
- ❑ Economic self-sufficiency
- ❑ Self-direction
- ❑ Learning new information/skills
- ❑ Capacity for independent living

Additional information as needed:

_____

_____

_____

_____ _____
Signature of Doctor/Medical Professional Date

_____ _____
Doctor/Medical Professional Name, Printed License Number

This form validates the SCSEP **most in need** (MIN) characteristic of disability as ascribed by the US Department of Labor's Division of Older Worker Program for data collection purposes and has no other intended or unintended use.