State of Illinois
Illinois Department on Aging

Attachment A Physician's Statement

You may need to complete Attachment A if you are 16-64 years of age as of January 1 and you are the claimant or you are the claimant's spouse/civil union partner, and you were determined totally and permanently disabled.

Step 1: Answer the following questions to determine if you should complete this attachment.

Note ***See Line-by-Line Instruction on the reverse side***.

1 Did you receive Social Security disability benefits last year? .....yes ☐ no ☐

2 Did you receive disability benefits from Railroad Retirement or Civil Service last year? .....yes ☐ no ☐

3 Did you receive 100% disability benefits from the Veterans Administration last year?.....yes ☐ no ☐

4 Did you have a Class 2 disability card from the Illinois Secretary of State's office last year?...yes ☐ no ☐

If you marked "yes" to any of the above, DO NOT complete the Attachment A.

Step 2: Complete the following information about yourself. Please print.

Note Complete a separate Attachment A for each person and submit as needed.

5 Social Security number ☐☐☐ ☐☐ ☐☐☐☐

9 Birth date ☐☐ (Month) ☐☐ (Day) ☐☐☐☐ (Year)

6 Name _____ (First / MI / Last)

10 Phone ( ) - ___ ___ ___ - ___ ___ ___ ___ (Area Code)

7 Address _____ Apt. _____

11 Claimant's Social Security number ☐☐☐ ☐☐ ☐☐☐☐

8 City _____ State _____ ZIP _____

Step 3: A physician must complete the following information about the person named on Line 6.

Note The patient must meet the total disability criteria established by the Social Security Administration. Social Security Administration guidelines do not include alcoholism or drug abuse as a qualification for disability status.

"Person with a disability" means a person unable to engage in any substantial gainful activity by reason of a 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. [320 ILCS 25/3.14]

12 Patient's name _____ (First / MI / Last)

13 Date patient became disabled ___ ___ / ___ ___ / ___ ___ ___ ___ (Month / Day / Year)

14 Was the patient able to work for a living after the above date?.....yes ☐ no ☐

15 Has the disability lasted or is it expected to continue for 12 months or more? .....yes ☐ no ☐

16 What is the nature of the disability? _____

Please see Social Security's Website at https://www.ssa.gov/planners/disability/dqualify4.html for information on what qualifies as a disability under Social Security guidelines.

I declare under penalty of perjury that I have personally examined the patient listed on this form and any accompanying statements or forms, and I have determined the patient to be a person with a disability using the same standards as used by the Social Security Administration.

17 Physician's name _____

18 Physician's signature and date _____ ___ ___ / ___ ___ / ___ ___ ___ ___ (Month / Day / Year)

19 Physician's Illinois registration number 36 - ___ ___ ___ ___ ___ ___

(This number is issued by the Illinois Department of Financial and Professional Regulation)

20 Physician's phone ( ) - ___ ___ ___ - ___ ___ ___ ___ (Area Code)

This form is authorized as outlined by the Senior Citizens and Disabled Persons Property Tax Relief and Pharmaceutical Assistance Act. Disclosure of this information is REQUIRED. Failure to provide information could delay your benefit. IL-402-1094

Line-by-Line instructions for Attachment A

You may need to complete Attachment A if you are 16 - 64 years of age on January 1 of this year, and you are the claimant or the claimant's spouse/civil union partner.

Note ***"Person with a disability" means a person unable to engage in any substantial gainful activity by reason of a 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. [320 ILCS 25/3.14]***

STEP 1: Answer the following questions to determine if you should complete this attachment or verify disability with one of the documents listed below.

1 through 4

If you answered

- If "Yes" to question 1 and you did not have an eligible Benefit Access Application from last year, attach one of the following ***instead*** of Attachment A:
  - a copy of Form SSA-1099 showing a Medicare deduction
  - a copy of your statement showing SSI benefits
  - a copy of your statement showing a Medicare deduction
- If "Yes" to question 2, attach the following item ***instead*** of Attachment A:
  - a copy of your pension statement from the Railroad Retirement or Civil Service agency stating that you were totally disabled or you had a deduction for Medicare
- If "Yes" to question 3, attach one of the following ***instead*** of Attachment A:
  - a copy of your pension statement
  - a copy of your statement showing compensation rated at 100 percent
- If "Yes" to question 4, attach the following item ***instead*** of Attachment A:
  - a copy of your Class 2 disability card from the Secretary of State's office.
- If "No" to all of the above questions complete Attachment A.

STEP 2: Complete the following information about yourself.

5 through 10

Complete the information about yourself (the person for whom Attachment A is being filed as proof of disability).

11 Write the claimant's Social Security number.

STEP 3: A physician must complete the following information about the person named on Line 6.

Present Attachment A to the physician of the person named on Line 6. The physician must complete Step 3.