Certification of Eligibility

(This form must be completed by a physician or licensed therapist to determine eligibility for the Community Support Grants Program. Upon completion, applicant should return this form, with the application, to New Trier Township to be postmarked no later than December 30, 2011)

Dear Professional,

Your patient/client is applying for the New Trier Township Community Support Grants Program. We require professional certification that the applicant is eligible. Under the program guidelines, individuals, children or adults, with the following disabilities, who are residents of New Trier Township, are eligible for a financial assistance program offered by New Trier Township:

- Autism Spectrum Disorders – A disability with disturbances in social interactions, communication, imaginative activity, and activities and interests.
- Developmental and/or Cognitive Delay – A developmental disability, which impairs adaptive behavior and daily functioning in varying degrees.
- Multiple Impairments – (1) A developmental disability, which constitutes a substantial disability attributable to intellectual disability, cerebral palsy, epilepsy, autism or a similar condition, and is expected to continue indefinitely. (2) Multiple disabilities physical, sensory, behavioral or cognitive functioning, which constitute a severe or profound impairment. Development substantially less than expected for the age in cognitive, affective or psychomotor behavior.
- Mental Disorders - A primary diagnosis according to DSM-IV diagnostic codes including, but not limited to schizophrenia, delusional disorder, schizoaffective disorder, bipolar affective disorder, atypical psychosis or major depression (recurrent). Functioning substantially impaired in areas such as self-maintenance, social functioning, activities of community living or work skills.
- Physical Impairments - An AVM rupture, epilepsy or other seizure disorders, hearing impairments, MI (heart), paralysis, TIA (stroke), and/or visual impairments.

Patient/Client Name		
Physician/Therapist Name		Phone
Office Address		
City	Zip Code	
Diagnosis (Please provide DSM-IV diagnostic code)		Date last seen
Physician/Therapist Signature	Provider License #	Date