



# THIS SIDE TO BE COMPLETED FOR QUALIFYING MEDICAL DISABILITY CRITERIA ONLY

## 섹션 IV – 의료정보 공개 승인

본인은, LACTOA 장애인 TAP 카드 신청과 관련해 Dr. \_\_\_\_\_ (으)로 하여금 본인의 장애와 관련된 의료 또는 기타 정보를 해당 기관에 공개할 수 있음을 승인합니다. 공개되는 본 정보는 본인의 상태와 본인의 장애 범주 지정을 확인하는데에만 사용될 것입니다.

본인은 본 승인서 사본을 받을 권리가 있으며, 언제든지 본 승인서를 취소할 수 있음을 이해합니다. 본 승인서를 취소하는 경우를 제외하고, 이 양식은 건강관리 전문가로 하여금 아래에 기재된 날짜로부터 최대 60 일 동안 관련 정보 공개를 위해 본인의 장애를 증명하게 할 수 있습니다.

신청인의 이름(인쇄체로 기입)

신청인의 서명

날짜

## SECTION V – MEDICAL PROFESSIONAL CERTIFICATION (FOR DOCTOR'S USE ONLY)

Qualified health care professionals who may certify disabilities listed in **SECTION VI**:

### M.D. & D.O. – ALL IMPAIRMENTS, ALL CATEGORIES

### AUDIOLOGIST – HEARING IMPAIRMENTS **O, P ONLY**

### CHIROPRACTORS – MOBILITY IMPAIRMENTS **A, B, D ONLY**

### PODIATRIST – MOBILITY IMPAIRMENTS **A, B, C, D ONLY**

### OPTOMETRIST – VISUAL IMPAIRMENTS **K, L ONLY**

### CLINICAL PSYCHOLOGISTS – MENTAL IMPAIRMENTS **M, N ONLY**

In order to certify an individual for the Disabled TAP card you must:

- > Agree to only certify, as eligible, those individuals who meet the criteria in **SECTION VI**.
- > Upon request, provide verification of the information contained on this application to qualifying agency.
- > Possess the proper professional degree and be licensed in California.

I hereby certify that the applicant's Medical Disability Criteria defined in **SECTION VI** is/are (circle all letters that apply)

**A B C D E F G H I J K L M N O P**

In the space provided below, doctor must indicate in detail applicant's disability. (Required)

In my professional judgment the applicant's disability is expected to continue for ( ) years, ( ) months.

(Note: TAP Identification Cards will not be issued for less than 3 months or more than 3 years.)

I understand that failure to certify applicant disabilities in accordance with the above guidelines will result in cancellation of my certification privileges. I am legally licensed \_\_\_\_\_ as a in the State of California and under the penalty of perjury, I hereby declare that the information provided is true and correct.

ENTER TITLE OF QUALIFIED PROFESSION

## MEDICAL PROFESSIONAL INFORMATION

Doctor's Full Name

License No.

Address

Suite

City, State, Zip

Telephone Number

Fax Number

Signature

Date of Execution

## SECTION VI – MEDICAL DISABILITY CRITERIA

### MOBILITY IMPAIRMENTS

- A** Non-ambulatory: Requires use of a wheelchair.
- B** Mobility-Aided: Requires use of an AFO or larger leg brace, walker, or crutches to achieve mobility.
- C** Arthritis: Therapeutic Grade III or worse, Functional Class III or worse, Anatomical Grade III or worse.
- D** Amputation/Deformity: Traumatic loss of muscle mass or tendons or x-ray evidence of bony or fibrous ankylosis, joint subluxation or instability of both hands, one hand and foot, or amputation at or above tarsal region.
- E** Stroke: Causing Pseudobulbar Palsy, sustained functional motor deficit of gross/dexterous movement or gait, ataxia affecting two extremities.

### PHYSICAL IMPAIRMENTS

- F** Respiratory: Class III or greater.
- G** Cardiac: Vascular impairments of Functional Class III or IV and Therapeutic Class C, D or E.
- H** Dialysis: Individuals who require kidney dialysis to live.
- I** Neurological Impairments: As contained in *Disability Evaluation Under Social Security Publication*.
- J** Chronic Progressive Debilitating Disorders: Diseases that are characterized by chronic symptoms such as fatigue, weakness, weight loss, pain and changes in mental status which interfere in daily living activities and **significantly impair mobility**.
  - > Progressive and uncontrollable malignancies
  - > Advanced connective tissue disease such as Lupus Erythematosus, Scleroderma or Polyarteritis Nodosa
  - > Symptomatic HIV: (AIDS or ARC) in CDC defined clinical group IV, Subgroups A-E

### VISUAL IMPAIRMENTS

- K** Legally Blind.
- L** Visual Acuity: No better than 20/200 after correction in best eye, or visual field is contracted to 10 degrees or less from point of fixation or subtends to angle no greater than 20 degrees.

### MENTAL IMPAIRMENTS

- M** Mental/Emotional: Individual with a mental or emotional impairment listed in *Diagnostic and Statistical Manual IV* of the American Psychiatric Association, the severity of which meets or exceeds standards outlined in the *Disability Evaluation Under Social Security Publication*. Disability must have been present for at least 3 months and be expected to continue for at least 3 months past the application date.
- N** Autism: Syndrome consisting of withdrawal, inadequate social relationships, language disturbance and monotonously repetitive motor behavior.

### HEARING IMPAIRMENTS

- O** Total deafness.
- P** Persons whose hearing loss is 70 dba or greater in the 1000 and 2000 Hz ranges.

[See back for more information. →](#)