For DPS Office Use Only

Intake Date: _____
Date Referred to Council: _____
Date of Recommendation:

SCHEDULE G

Disability Declaration Affidavit for Business Enterprise owned by People with Disabilities (BEPD)

_____
Full Legal Name of Firm (name written exactly as stated on Articles of Incorporation, Articles of Organization or Assumed Name Certificate)

_____
Contact Person and Title Contact Person Telephone Number

In accordance with the Municipal Code of Chicago as amended to include Section 2-92-586, the City of Chicago allows for individuals with disabilities to become certified as a Business Enterprise owned by People with Disabilities (BEPD). In order for a firm to submit a Schedule A for certification as a BEPD, it must first be determined if the owners are indeed individual(s) with disabilities.

Section 2-92-586 defines Disability with respect to an individual as:

a. A medically diagnosed severe physical or mental impairment that substantially limits one or more of the major life activities of that individual, such as mobility, communication, self-care, self-direction, interpersonal skills, work tolerance or work skills in terms of employability;
b. A record of such an impairment; or
c. Being regarded as having such impairment.

The Code further defines firms owned or operated by individuals with disabilities as entities that meet one of the following criteria:

a. A for-profit corporation, partnership, association, business trust, estate or other legal entity that is either owned (directly, indirectly or beneficially) 51 percent or more by one or more individuals with disabilities and whose management and daily business operations are controlled by one or more individuals with disabilities; or
b. A nonprofit corporation that employs individuals with disabilities, pays them an hourly wage that is not less than the federal minimum wage and not on a piece work basis, and a) whose management and daily business operations are controlled by one or more individuals with disabilities, and b) whose corporate purpose includes providing, directly or indirectly, services to individuals with disabilities; or
c. An individual with a disability who is contracting with the City as a sole proprietorship or individually.

Given the definitions outlined above, this firm is: (Check where appropriate)

- ❑ A for-profit corporation or sole proprietorship
- ❑ A non-profit corporation

Non-profit corporations need to submit the following in addition to information requested on the Schedule A:

- *An organizational packet describing the mission of the organization.*
- *An organizational chart with indications of which employees are individuals with disabilities.*
- *A Physician's Certification Regarding Disability for any and all members of the board of directors or senior management that are individuals with disabilities. This includes a narrative from the physician certifying the disability on letterhead from their practice, group or hospital that clearly describes the functional limitation of each individual with the disability.*
- *A current annual report.*
- *List of the contributions of money, equipment, or real estate made by any donors or founders to establish the organization.*

For-profit corporations need to submit the following in addition to information requested on the Schedule A:

- *A Physician's Certification Regarding Disability for all owners, officers or directors that are individuals with disabilities. This includes a narrative from the physician certifying the disability on letterhead from their practice, group or hospital that clearly describes the functional limitation of each individual with the disability.*

PLEASE NOTE: All Physician's Certification Regarding Disability forms must be in their entirety and be accompanied by a narrative that describes the functional limitations of the declared disability. Also, the affidavit and the physician's statement(s) must include original signatures when submitted to the City of Chicago.

All qualifying individuals must sign the following affidavit. Make copies of this form if necessary.

I authorize the City of Chicago's Department of Procurement Services or appointed designee to verify the accuracy of the statements contained herein to determine whether the applicant meets the disability standards outlined in the City of Chicago's BEPD certification program. Under penalty of perjury, I certify that I have personal knowledge of the statements being made in this Disability Declaration Affidavit for Business Enterprise owned by People with Disabilities, and that they are complete and true.

_____

Applicant Firm Name

_____

Qualifying Individual's Name (Type/Print) Title

_____

Signature Date Signed

State of _____ County of _____

Signed and sworn (or affirmed) before me on this _____ day of _____ 20 _____.

_____

Notary Signature

My commission expires on: _____ Notary Seal

Physician's Certification Regarding Disability

(Form may be duplicated as necessary for each individual with a disability.)

THIS SECTION TO BE COMPLETED BY THE INDIVIDUAL WITH A DISABILITY:

Full Name: Signature:

Position/Title:

Disability: 1. _____

2. _____

3. _____

Self-indication off functional limitations: (Check all that apply and attach a narrative description on medical personnel's letterhead that supports self-indication.)

- ❑ Mobility
- ❑ Communication
- ❑ Self-Care
- ❑ Self-Direction
- ❑ Interpersonal skills
- ❑ Work Tolerance
- ❑ Work Skills
- ❑ Other: _____

THIS SECTION TO BE COMPLETED BY PHYSICIAN:

Name of Patient	ICD—CM Diagnosis Code(s)	Date of onset of Disability (MM/DD/YY)	Date Patient First Consulted You (MM/DD/YY)

Please type and attach a detailed description of any substantial and continuing functional limitations resulting from the diagnosed disability that support the individual's self indication above. This should include the probable duration of the limitations and the prognosis for recovery. The description must be signed by the certifying physician on their letterhead and include the professional medical license number.

I certify that all of the statements made above and any attached information is true and correct and understand that submitting and/or attesting to any false information subjects me to the appropriate penal code of Illinois.

Signature of Certifying Physician _____ Date _____ Telephone Number _____

Professional Medical License Number _____