Cook County Disability Declaration Affidavit for Persons with Disabilities Owned Business Enterprise (PDBE)

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Full Legal Name of Applicant Firm

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Address

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Applicant Owner's Name and Title | Email | Telephone Number

In accordance with Section 34-242. of the Cook County Code of Ordinances (the "Code"), Cook County Government allows for certification of Businesses Owned by People with Disabilities (PDBE). In order to submit a Schedule A for certification as a PDBE, applicants must provide documentation establishing their qualification for certification under the Cook County Code of Ordinances.

Definitions:
Persons with Disabilities Owned Business Enterprise (PDBE) means a small business:
(1) That is at least 51 percent owned, controlled, and managed by one or more qualified, economically disadvantaged Disabled Persons; and
(2) That has its home office in Illinois.

Small Business means a small business as defined by the U.S. Small Business Administration, pursuant to the business size standards found in 13 CFR Part 121, as related to the nature of the work the Business seeks to perform on Contracts. A Person is not an eligible small business enterprise in any calendar fiscal year in which its gross receipts, averaged over the Business's previous five fiscal years, exceed the size standards of 13 CFR Part 121.

Economically Disadvantaged, with respect to an individual, means having a Personal Net Worth less than $2,000,000.00, indexed annually for the Chicago Metro Area Consumer Price Index for Urban Wage Earners and Clerical Workers, published by the U.S. Department of Labor, Bureau of Labor Standards, beginning January 2008.

Disability or Disabled means, with respect to an individual, a physical or mental impairment that substantially limits one or more of the major life activities of the individual, a record of physical or mental impairment that substantially limits one or more of the major life activities of the individual, or being regarding as an individual with physical or mental impairment that substantially limits one or more of the major life actives of the individual.

Applicants must submit the following in addition to information requested on the Schedule A Application and Schedule A Checklist:

- ☐ A Physician's Certification Regarding Disability form for all owners that are individuals with disabilities. This includes a narrative from each individual's physician, on letterhead from the physician's practice, group, or hospital, certifying the individual's disability and clearly describing the functional limitation of the declared disability.
- ☐ Service-Disabled Veteran applicants must submit Department of Defense Form 214 and Veterans Administration issued disability letter stating that the veteran has a service-related disability.

PLEASE NOTE: All Physicians' Certification Regarding Disability forms must be completed 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 upon submission to Cook County Office of Contract Compliance.

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

I authorize the Cook County Office of Contract Compliance and its appointed designee(s) to verify the accuracy of the statements contained herein to determine whether the applicant meets the disability standards outlined in Cook County's PDBE Certification Program. Under penalty of perjury, I certify that I have personal knowledge of the statements being made in this Disability Declaration Affidavit for Persons with Disabilities Owned Business Enterprise, and that they are complete and true.

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Full Legal Name of Applicant Firm

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Qualifying Owner's Name   Title

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Applicant Owner's Signature   Date Signed

Notary:

State of ________________________

County of ______________________

Signed and Sworn before

me on the ______________________

day of _______ 20________________.

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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 of functional limitations: (Check all that apply and attach a narrative description on Physician'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:

Patient Name:	Diagnosis Codes and Description:	Date of Onset of Disability:	Date Patient First Consulted You:

Please type and attached 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 including the professional license number.

I certify that the statements made above, and any attached information is true and correct and I understand that submitting any/or attesting to any false information subjects me to penalties under the Cook County Code of Ordinances and the laws of the State of Illinois.

Signature of Certifying Physician ________________________________

Date ______________

Telephone Number ____________________

Professional Medical License Number ________________________________