DISABILITY REPORT – Form DHR/FIA – 3368
COMPLETING THIS FORM

THIS IS NOT AN APPLICATION

HOW TO COMPLETE THIS FORM

The information that you give us on this form will be used by the office that makes the disability determination.

- Please fill out as much of this form as you can.
- Print clearly.
- **DO NOT LEAVE ANSWERS BLANK**. If you do not know the answer, or the answer is "none" or "does not apply," please write: "don't know,", or "none," or "does not apply."
- **IN SECTION 4, PUT INFORMATION FOR ONLY ONE DOCTOR/THERAPIST/HOSPITAL/CLINIC IN EACH SPACE**.
- Each address should include a ZIP code. Each telephone number should include an area code.
- When a question refers to "you," "your" or the "Disabled Person," it refers to the person who is applying for Medical Assistance benefits. If you are filling out the form for someone else, please provide information about him or her.
- Be sure to explain an answer if the question asks for an explanation, or if you want to give additional information.
- If you need more space to answer any questions or want to tell us more about an answer, please use the "REMARKS" section on Page 9 and show the number of the question being answered.

ABOUT YOUR MEDICAL RECORDS

If you have any medical records and copies of prescriptions at home for the person who is applying for Medical Assistance benefits, send them to our office with your completed forms or bring them with you to your interview.

YOU DO NOT NEED TO ASK DOCTORS OR HOSPITALS FOR ANY MEDICAL RECORDS THAT YOU DO NOT ALREADY HAVE. With your permission we will do that for you. The information we ask for on this form tells us to whom we should send a request for medical and other records. If you cannot remember the names and addresses of any of the doctors or hospitals, or the dates of treatment, perhaps you can get this information from the telephone book, or from medical bills, prescriptions and prescription bottles.

If you need the records back, tell us and we will photocopy them and return them to you.

DISABILITY REPORT

For Local Department and State Review Team use Only
Do not write in this box.

Client ID#_____

Medical Assistance AU#_____

SECTION 1 – INFORMATION ABOUT THE DISABLED PERSON

A. **NAME** (First, Middle Initial, Last)

B. **SOCIAL SECURITY NUMBER**

C. **DAYTIME TELEPHONE NUMBER** *(If you have no number where you can be reached, give us a daytime number where we can leave a message for you.)*

_____ _____ (Your Number (Message Number
Area Code Number

D. Give the name of a **friend or relative** that we can contact (other than your doctors) **who knows about your illnesses, injuries or conditions** and can help with your application.

NAME_____ RELATIONSHIP_____

ADDRESS_____
(Number, Street, Apt. No. (If any), P.O. Box, or Rural Route)

_____ DAYTIME PHONE _____ _____
City State Zip Area Code Number

E. What is your **height** without shoes? _____ feet _____ inches

F. What is your **weight** without shoes? _____ pounds

G. Have you applied for Social Security benefits ? ☐ NO ☐ YES If **YES** when:

MONTH	DAY	YEAR

H. Can you **speak and understand English?** ☐ YES ☐ NO

If you cannot **speak and understand English,** is there someone we may contact who speaks and understands English and will give you messages? ☐ YES ☐ NO (If "YES", and that person is the same as in "D" above write "SAME" here:_____. If not, complete the following information.)

NAME_____ **RELATIONSHIP**_____

ADDRESS_____
(Number, Street, Apt. No. (If any), P.O. Box, or Rural Route)

_____ **DAYTIME PHONE** _____ _____
City State ZIP **Area Code Number**

I. Can you **read and understand English?** ☐ YES ☐ NO

J. Can you **write more than your name in English?** ☐ YES ☐ NO

K. Can you **Speak English?** ☐ YES ☐ NO

SECTION 2
YOUR ILLNESSES, INJURIES OR CONDITIONS AND HOW THEY AFFECT YOU

A. What are the illnesses, injuries or conditions that limit your ability to work? _____

B. How do your illnesses, injuries or conditions limit your ability to work? _____

C. Do your illnesses, injuries or conditions cause you **pain** or **other symptoms**? ☐ YES ☐ NO

D. When did your illnesses, injuries or conditions **first interfere with your ability to work?**

Month	Day	Year

E. When did you become **unable to work** because of your illnesses, injuries or conditions?

Month	Day	Year

F. Have you **ever worked**? ☐ YES ☐ NO (If "NO," go to Section 4.)

G. Did you **work at any time** after the date of your illnesses, injuries or conditions first interfered with your ability to work ? ☐ YES ☐ NO

H. If "YES", did your illnesses, injuries or conditions cause you to: *(check all that apply)*

- ☐ **work fewer hours**? *(Explain below)*
- ☐ **change your job duties**? *(Explain below)*
- ☐ **make any job-related changes such as your attendance, help needed, or employers?** *(Explain below)*

I. Are you **working now**? ☐ YES ☐ NO

If "NO," when did **you stop working**?

Month	Day	Year

J. Why did you **stop working**?

SECTION 3 – INFORMATION ABOUT YOUR WORK

A. List all the jobs that you had in the 15 years before you became unable to work because of your illnesses, injuries or conditions.

JOB TITLE (Example:Cook)	TYPE OF BUSINESS (Example:Restaurant)	DATE WORKED (month & year)		HOURS PER DAY	DAYS PER WEEK	RATE OF PAY (per hour, day, week, month, or year)	
		From	To				
						$	
						$	
						$	
						$	
						$	
						$	
						$	

B. Which job did you do the longest?_____

C. Describe this job. What did you do all day? (If you need more space, write in the "Remarks" section.)

_____

_____

D. In **this job**, did you:

Use machines, tools or equipment? ☐ YES ☐ NO

Use technical knowledge or skills? ☐ YES ☐ NO

Do any writing, complete reports, or perform duties like this? ☐ YES ☐ NO

E. In **this job**, how many total hours each day did you:

Walk? _____ Stoop? *(Bend down & forward at waist.)* _____ Handle, grab or grasp big objects? _____

Stand? _____ Kneel? *(Bend legs to rest on knees.)* _____ Reach? _____

Sit? _____ Crouch? *(Bend legs & down & forward)* _____ Write, type or handle small objects? _____

Climb? _____ Crawl? *(Move on Hands & knees.)* _____

F. Lifting and Carrying *(Explain what you lifted, how far you carried it, and how often you did this.)*

_____

_____

G. Check **heaviest** weight lifted:

☐ Less than 10 lbs ☐ 10 lbs ☐ 20 lbs ☐ 50 lbs ☐ 100 lbs. or more ☐ Other_____

H. Check weight **often** lifted: *(By frequently, we mean from 1/3 to 2/3 of the workday.)*

☐ Less than 10 lbs ☐ 10 lbs ☐ 25 lbs ☐ 50 lbs or more ☐ Other_____

I. Did you supervise other people in this job? ☐ YES *(Complete items below.)* ☐ NO *(If No, go to J.)*

How many people did you supervise? _____

What part of your time was spent supervising people? _____

Did you hire and fire employees? ☐ YES ☐ NO

J. Were you a lead worker? ☐ YES ☐ NO

SECTION 4 – INFORMATION ABOUT YOUR MEDICAL RECORDS

A. Have you been seen by a **doctor/hospital/clinic** or anyone else for the illnesses, injuries or conditions that limit your ability to work? ☐ YES ☐ NO

B. Have you been seen by a **doctor/hospital/clinic** or anyone else for emotional or mental problems that limit your ability to work? ☐ YES ☐ NO

If you answered "NO" to both of these questions, go to Section 5

C. List **other names** you have used on your medical records._____

_____

Tell us who may have medical records or other information about your illnesses, injuries or conditions.

D. **List each DOCTOR/HMO/THERAPIST/OTHER.** Include your **next appointment.**

1.

NAME			DATES
STREET ADDRESS			**FIRST** VISIT
CITY	**STATE**	**ZIP**	**LAST** SEEN
PHONE Area Code Phone Number	**PATIENT ID #** (If known)		NEXT **APPOINTMENT**

REASONS FOR VISITS_____

_____

WHAT **TREATMENT** WAS RECEIVED?_____

_____

_____

2.

NAME			DATES
STREET ADDRESS			**FIRST** VISIT
CITY	**STATE**	**ZIP**	**LAST** SEEN
PHONE Area Code Phone Number	**PATIENT ID #** (If known)		NEXT **APPOINTMENT**

REASONS FOR VISITS_____

_____

DOCTOR/HMO/THERAPIST/OTHER

3. **SECTION 4 – INFORMATION ABOUT YOUR MEDICAL RECORDS**

NAME			DATES
STREET ADDRESS			**FIRST** VISIT
CITY	**STATE**	**ZIP**	**LAST** SEEN
PHONE Area Code Phone Number	**PATIENT ID #** (If known)		NEXT **APPOINTMENT**
REASONS FOR VISITS			
WHAT **TREATMENT** WAS RECEIVED?			

If you need more space, use Section 9

E. **List each HOSPITAL/CLINIC. Include your next appointment.**

1.

HOSPITAL/CLINIC			TYPE OF VIST	DATES	
NAME			☐ INPATIENT STAYS (Stayed at least overnight)	DATE IN	DATE OUT
STREET ADDRESS					
				DATE FIRST VISIT	DATELAST VIST
CITY	STATE	ZIP	☐ OUTPATIENT VISITS (Sent home same day)	DATES OF VISITS	
PHONE Area Code Phone Number			☐ EMERGENCY ROOM VISITS		

Next **appointment**_____

Reasons for visits_____

What **treatment** did you receive?_____

What **doctors** do you see at this hospital/clinic on a regular basis?_____

SECTION 4 – INFORMATION ABOUT YOUR MEDICAL RECORDS.
List any Hospital/Clinic that may have your medical records

HOSPITAL/CLINIC

2.

HOSPITAL/CLINIC			TYPE OF VISIT	DATES	
NAME			☐ INPATIENT STAYS (Stayed at least overnight)	DATE IN	DATE OUT
STREET ADDRESS					
				DATE FIRST VISIT	DATE LAST VISIT
CITY	STATE	ZIP	☐ OUTPATIENT VISITS (Sent home same day)		
				DATES OF VISITS	
PHONE Area Code Phone Number			☐ EMERGENCY ROOM VISITS		

Next **appointment** _____

Reasons for visits _____

_____

What **treatment** did you receive? _____

_____

What **doctors** do you see at this hospital/clinic on a regular basis? _____

_____

If you need more space, use Remarks, Section 9.

F. Does **anyone else have medical records or information** about your illnesses, injuries or conditions (Workers' Compensation, insurance companies, prisons, attorneys, welfare), or are you scheduled to see anyone else?

☐ YES (If "YES," complete information below.) ☐ NO

NAME			DATES
STREET ADDRESS			**FIRST** VISIT
CITY	**STATE**	**ZIP**	**LAST** SEEN
PHONE Area Code Phone Number	**PATIENT ID #** (If known)		NEXT APPOINTMENT
CLAIM NUMBER (If any) _____			
REASONS FOR VISITS _____			

If you need more space, use Remarks, Section 9.

SECTION 5 - MEDICATIONS

Do you currently take any medications for your illnesses, injuries or conditions? ☐ YES
If "YES," please tell us the following: *(Look at your medicine bottles, if necessary.)* ☐ NO

NAME OF MEDICINE	IF PRESCRIBED, GIVE NAME OF DOCTOR	REASON FOR MEDICINE	SIDE EFFECTS YOU HAVE

If you need more space, use Remarks, Section 9.

SECTION 6 - TEST

Have you had, or will you have any medical test for illnesses, injuries or conditions?
☐ YES ☐ NO If "YES," please tell us the following: *(Give approximate dates, if necessary.)*

KIND OF TEST	DATE WHEN DONE, OR WHEN IT WILL BE DONE? (Month, day, year)	WHERE WAS IT DONE? (Name of Hospital/Clinic)	WHO SENT YOU FOR THIS TEST?
EKG (HEART TEST)			
TREADMILL (EXERCISE TEST)			
CARDIAC CATHETERIZATION			
BIOPSY – Name of body part _____			
HEARING TEST			
SPEECH/LANGUAGE TEST			
VISION TEST			
IQ TESTING			
EEG (BRAIN WAVE TEST)			
HIV TEST			
BLOOD TEST (NOT HIV)			
BREATHING TEST			
X-RAY – Name of body part _____			
MRI/CT SCAN Name of body part_____			

If you have had other tests, list them in Remarks, Section 9.

SECTION 7 – EDUCATION/TRAINING INFORMATION

A. Check the highest grade of school completed.

Grade school:

0	1	2	3	4	5	6	7	8	9	10	12	GED
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

College:

1	2	3	4 or more
☐	☐	☐	☐

Approximate **date** completed: _____

B. Did you attend special education classes? ☐ YES ☐ NO (If "NO," go to part C)

NAME OF SCHOOL _____

ADDRESS _____
(Number, Street, Apt. No. (if any), P.O. Box or Rural Route)

_____
City State Zip

DATES ATTENDED _____ TO _____

TYPE OF PROGRAM _____

C. Have you completed any type of **special job training, trade or vocational school?**

☐ YES ☐ NO If "YES," what type? _____

Approximate date completed: _____

SECTION 8 – VOCATIONAL REHABILITATION, EMPLOYMENT, or OTHER SUPPORT SERVICES INFORMATION

Have you participated, or are you participating in:

- an individual work plan with an employment network under the Ticket to Work Program;
- an individualized plan for employment with a vocational rehabilitation agency or any other organization;
- a Plan to Achieve Self-Support;
- an individualized education program through an educational institution (if a student age 18 – 21); or
- any program providing vocational rehabilitation, employment services, or other support services to help you go to work?

☐ YES (Complete the information below) ☐ NO

NAME OF ORGANIZATION _____

NAME OF COUNSELOR _____

ADDRESS _____
(Number, Street, Apt. No. (if any), P.O. Box or Rural Route)

_____
City State Zip

DAYTIME PHONE NUMBER _____ _____
Area Code Number

DATES SEEN _____ TO _____

TYPE OF SERVICES OR TEST PERFORMED _____
(IQ, vision, physicals, hearing, workshops, etc.)

SECTION 9 – REMARKS

Use this section for any added information you did not show in earlier parts of this form. When you are finished with this section (or if you don't have anything to add), be sure to complete the information at the bottom of this page.

If the person completing this form is someone other than the disabled person or the person identified in Section 1. Item D, please complete the following information

Name of person completing this form if other than the disabled person *(Please Print)*	**Date Form Completed** *(Month, day, year)*
Address (Number and street)	**e-mail address** *(optional)*
City **State**	**Zip Code**

Relationship to Disabled Person	**Daytime Telephone Number** ( ) -