

# Hand Outs

**Attachment II**

**Benefits Planning Assistance and Outreach  
Cooperative Agreement Awards in New York State**

<b>BPA&amp;O Awardee</b>	<b>Address</b>	<b>Phone Number</b>	<b>Service Area</b>
<b>Abilities, Inc. for Disability Services</b>	201 I.U. Willets Road, Albertson, NY 11507	(516) 465-1522	Nassau & Suffolk Counties of Long Island NY
<b>Barrier Free Living, Inc.</b>	270 East Second Street, New York, New York 10009	(212) 677-6668 x 123	New York and Richmond Counties (Staten Island)
<b>Independent Living, Inc.</b>	5 Washington Terrace, Newburgh, NY 12550	(845) 565-1162 x 224	Albany, Columbia, Dutchess, Greene, Orange, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Sullivan, Ulster, and Westchester Counties
<b>Neighborhood Legal Services, Inc.</b>	295 Main Street, Room 495, Buffalo, NY 14203	(716) 847-0655 x 262	Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Livingston, Monroe, Niagara, Ontario, Orleans, Schuyler, Seneca, Steuben, Wayne, Wyoming, and Yates Counties
<b>Queens Independent Living Center, Inc.</b>	140-40 Queens Boulevard, Jamaica, NY 11435	(718) 658-2526	Bronx and Queens Counties
<b>Research Foundation for Mental Hygiene</b>	44 Holland Avenue, 6 <sup>th</sup> Floor, Albany, NY 12229	(518) 485-2584	Kings County (Brooklyn - Brooklyn Works)
<b>Resource Center for Independent Living</b>	401-409 Columbia Street, PO Box 210, Utica, NY 13503	(315) 797-4642	Broome, Cayuga, Chemung, Chenango, Clinton, Cortland, Delaware, Essex, Franklin, Fulton, Hamilton, Herkimer, Jefferson, Lewis, Madison, Montgomery, Oneida, Onondaga, Oswego, Otsego, St. Lawrence, Schoharie, Tioga, Tompkins, Warren, and Washington Counties



**ATTACHMENT VII**

**MEDICAID BUY-IN FOR WORKING PEOPLE WITH DISABILITIES (MBI-WPD)  
GRACE PERIOD REQUEST FORM**

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

COUNTY: \_\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_

I AM REQUESTING A GRACE PERIOD FOR CONTINUED PARTICIPATION IN THE MBI-WPD FOR THE FOLLOWING REASON:

CHANGE IN MEDICAL CONDITION: (medical verification needed)

Verification Attached (physician's statement)

Date of Last Day Worked: \_\_\_\_\_

JOB LOSS (through no fault of the participant)

\_\_\_\_\_ This is a temporary layoff. My anticipated return date is \_\_\_\_\_.

\_\_\_\_\_ I am actively seeking new employment.

Verification Attached (e.g., layoff notice, statement from Department of Labor, VESID, etc.)

Please Explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Date of Last Day Worked: \_\_\_\_\_

I certify, under penalty of perjury, that the information I have provided on this request form is true and complete to the best of my knowledge.

\_\_\_\_\_  
Print Full Name

\_\_\_\_\_  
Signature of Application

\_\_\_\_\_  
Date

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To be Completed by the Local District Social Services Office

LDSS Contact: \_\_\_\_\_

Phone #: \_\_\_\_\_

REQUEST APPROVED Date: \_\_\_\_\_

Grace Period: \_\_\_\_\_ to \_\_\_\_\_

REQUEST DENIED Date: \_\_\_\_\_

Reason for Denial: \_\_\_\_\_

\_\_\_\_\_  
Signature of LDSS Contact

\_\_\_\_\_  
Date

## **MBI-WPD GRACE PERIOD INSTRUCTIONS**

### **What Are Grace Periods?**

A grace period is a time period during which MBI-WPD program participant is not working but remains eligible for the program. Two types of grace periods may be granted:

- **Medical Reasons:** a grace period of up to six months will be allowed if, for medical reasons, the MBI-WPD participant is unable to continue working. Medical verification will be required. When an applicant requests this type of grace period, LDSS must request medical verification.
- **Grace Period for Job Loss:** a grace period of up to six months will be allowed if, no fault of the participant, job loss is suffered, i.e., due to layoff, etc. Verification is required. Districts must verify that the recipient is reasonably expected to return to employment, for example, a temporary layoff, or that the recipient is actively seeking new employment.

Note: MBI-WPD participants reporting job loss due to non-medical reasons should be referred to One-Stop Centers, VESID and BPAO services as applicable, so that assistance with employment may be sought prior to loss of eligibility in the program.

### **How Do I Go About Getting a Grace Period?**

A MBI-WPD participant must complete a grace period request on the opposite side of this form. The completed form, along with the required documentation must be submitted to your Local District Social Services (LDSS) office.

### **How Often Can I Have a Grace Period?**

Recipients may be granted multiple grace periods during a 12-month period. However, in no event may the sum of the grace periods exceed six months in the 12-month period.

### **What Kind of Documentation Do I Need?**

When applying for a Change in Medical Condition Grace Period, a physician's statement is required which contains the current health problem, treatment and the anticipated amount of time you will be out of work.

When applying for a Job Loss Grace Period, verification is also required. Acceptable forms of verification include layoff notice, statement from Department of Labor, VESID, etc.

### **How Will I Know if My Grace Period is Approved?**

Your LDSS office will send you a letter informing you of your approval and the period of time authorized. Remember, the sum of your grace periods cannot exceed six months in a 12-month period.

### **What Happens When I Return to Work?**

You should immediately notify your LDSS office of your return to work. Unless you inform the LDSS office of your return to work, your grace period continues throughout the approved period. This is important because the sum of the grace periods cannot exceed six months in a 12-month period.

### **Will My Grace Period Affect My Premium Payments?**

Premium payments are calculated on the applicant's net (earned and unearned) income between 150% and 250% of the FPL. You must notify your LDSS office immediately of any change in income. The LDSS office will use this information to re-calculate your premium payments.

## CLIENT NOTICES SYSTEM MA MBI-WPD PROGRAM

Reason Code	Paragraph #	Definition	Case Type	Notice Ind
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**DENIALS:**

*B43	D0147	Deny MBI-WPD Not a State Resident	20	A
*B44	D0149	Deny MBI-WPD Failed to Provide A Medical Statement	20	A
*B45	D0150	Deny MBI-WPD Death Before Determination, Insufficient Info to Make a Determination	20	A
*B46	D0151	Deny MBI-WPD Death Before Determination, No Medical Bill In Retro Period	20	A
U19	D0152	Deny MBI-WPD Excess Income and/or Resources #	20	A
U47	D0153	Deny MBI-WPD Non Financial Reasons	20	A

**DISCONTINUANCE:**

*B42	C0238	Disc MBI-WPD Client Request	20	T
*B43	C0237	Disc MBI-WPD Not a State Resident	20	T
U46	C0245	Disc MBI-WPD Non Financial Reasons	20	T
U18	C0188	Disc MBI-WPD Excess Income and/or Resources #	20	T

\* No-Fill Reason Codes

# Requires Stored Budget

Reason Code	Paragraph #	Definition	Case Type	Notice Ind
<b><u>UNDERCARE:</u></b>				
*B47	U0146	MA to MBI-WPD, Limited Coverage #	20	T
*B51	U0127	MA to MBI-WPD, Full Coverage #	20	T
*B52	X0224	Spenddown to MBI-WPD, Limited Coverage #	20	T
*B53	X0222	Spenddown to MBI-WPD, Full Coverage #	20	T
U16	U0145	MBI-WPD to MA, Limited Coverage #	20	T
U17	U0125	MBI-WPD to MA, Full Coverage #	20	T

\* No-Fill Reason Code

# Requires Stored Budget

**MBI-WPD**  
**Sample Grace Period Letter**  
**For**  
**Medical Condition**

Address/Letterhead

Date

Dear \_\_\_\_\_:

This letter will confirm the approval of your request for a grace period in the Medicaid Buy-In program for Working People with Disabilities (MBI-WPD) due to a change in your medical condition. This grace period is effective \_\_\_\_\_ through \_\_\_\_\_. Your participation in the MBI-WPD program means that your Medicaid coverage will not be interrupted during this grace period.

When there is again a change in your medical condition such that you can return to work, you must notify the local Department of Social Services in writing and submit verification of employment, i.e. a copy of your first pay stub. At that time, you will no longer be in a grace period as you will, once again, be considered an actively employed participant in the MBI-WPD program.

If you are unable to return to work by \_\_\_\_\_, and require an extension of this grace period, you will be required to request the extension in writing and document your medical condition with a letter from your physician. Remember that for the MBI-WPD program, no more than six months grace period may be allowed in a twelve month period.

Please contact me if you have any further questions.

Sincerely,

Signature

**MBI-WPD**  
**Sample Grace Period Letter**  
**For**  
**Job Loss**

Address/letterhead

Dear \_\_\_\_\_:

This letter will confirm the approval of your request for a grace period in the Medicaid Buy-In program for Working People with Disabilities (MBI-WPD) due to job loss. This grace period is effective \_\_\_\_\_ through \_\_\_\_\_. Your participation in the MBI-WPD program means that your Medicaid coverage will not be interrupted during this grace period.

Once you have secured a new job, you must notify the local Department of Social Services in writing and submit verification of employment, i.e. a copy of your first pay stub. At that time, you will no longer be in a grace period as you will, once again, be considered an actively employed participant in the MBI-WPD program.

If you do not obtain a job by \_\_\_\_\_, and require an extension of this grace period, you will be required to request the extension in writing and document your efforts to actively seek employment during the time of the current grace period. Documentation of employment-seeking means you must keep a job interview record containing the following:

1. The date of each job interview that you have attended.
2. The name and title of the individual who conducted the interview and the address and phone number of the business or agency where the interviews took place.
3. The outcome of each interview (offered a job, or were not offered a job).
4. If you declined a job offer, the reason you declined.
5. If a VESID counselor is assisting you in your job-seeking efforts, written verification from the VESID counselor will be accepted as supportive documentation, as long as it contains the information in your job interview record.

We wish you luck in your efforts to obtain employment.

Sincerely,

Signature



**RIGHT TO A CONFERENCE:** You may have a conference to review these actions. If you want a conference, you should ask for one as soon as possible. At the conference, if we discover that we made the wrong decision or if, because of information you provide, we determine to change our decision, we will take corrective action and give you a new notice. You may ask for a conference by calling us at the number on the first page of this notice or by sending a written request to us at the address listed at the top of the first page of this notice. This number is used only for asking for a conference. ***It is not the way you request a fair hearing.*** If you ask for a conference you are still entitled to a fair hearing. If you want to have your benefits continue unchanged (aid continuing) until you get a fair hearing decision, you must request a fair hearing in the way described below. Read below for fair hearing information.

**RIGHT TO A FAIR HEARING:** If you believe that the above action is wrong, you may request a State fair hearing by:

**(1) Telephone:** (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL)

The new Statewide toll-free request number is (800) 342-3334 **OR**

**(2) Fax:** Send a copy of this notice to fax no. (518) 473-6735. **OR**

**(3) On-Line:** Complete and sending the online request form at: <https://www.otda.state.ny.us/oah/oahforms/erequestform.asp> **OR**  
<http://www.otda.state.ny.us/oah/forms.asp> **OR**

**(4) Write:** Send a copy of this notice **completed**, to the Fair Hearing Section, New York State Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

I want a fair hearing. The Agency's action is wrong because: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Print Name: \_\_\_\_\_ Case Number \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

Signature of Client: \_\_\_\_\_ Date: \_\_\_\_\_

**YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING**

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, paystubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

**CONTINUING YOUR BENEFITS:** If you request a fair hearing before the effective date stated in this notice, you will continue to receive your benefits unchanged until the fair hearing decision is issued. However, if you lose the fair hearing, we may recover the cost of any Medical Assistance benefits that you should not have received. If you want to avoid this possibility, check the box below to indicate that you do not want your aid continued, and send this page along with your hearing request. If you do check the box, the action described above will be taken on the effective date listed above.

I agree to have the action taken on my Medical Assistance benefits, as described in this notice, prior to the issuance of the fair hearing decision.

**LEGAL ASSISTANCE:** If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking your Yellow Pages under "Lawyers" or by calling the number indicated on the first page of this notice.

**ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS:** To help you get ready for the hearing, you have a right to look at your case file. If you call or write to us, we will provide you with free copies of the documents from your file, which we will give to the hearing officer at the fair hearing. Also, if you call or write to us, we will provide you with free copies of other documents from your file, which you think you may need to prepare for your fair hearing. To ask for documents or to find out how to look at your file, call us at the Record Access telephone number listed at the top of page 1 of this notice or write us at the address printed at the top of page 1 of this notice.

If you want copies of documents from your case file, you should ask for them ahead of time. They will be provided to you within a reasonable time before the date of the hearing. Documents will be mailed to you only if you specifically ask that they be mailed.

**INFORMATION:** If you want more information about your case, how to ask for a fair hearing, how to see your file, or how to get additional copies of documents, call us at the telephone numbers listed at the top of page 1 of this notice or write to us at the address printed at the top of page 1 of this notice.

**AVISO DE ELEGIBILIDAD PARA COBERTURA DE MEDICAID  
BAJO EL PROGRAMA DE TRATAMIENTO DE CÁNCER DE MAMA Y CÁNCER CERVICAL**

Fecha del aviso _____			Nombre y dirección de la agencia/Centro u oficina de distrito	
Número de Caso		Número CIN		
Nombre del Caso y Dirección			No. DE TELÉFONO GENERAL PARA HACER PREGUNTAS O PEDIR AYUDA _____	
			Conferencia con la agencia _____ and Assistance (800) 342-3334	
			Acceso a los archivos _____	
			Asistencia Legal _____	
No. de oficina	No. de unidad OCP	No. de trabajador(a) de casos BCCTP	Nombre del trabajador(a)	No. de teléfono

ACEPTAREMOS su solicitud para Asistencia Médica de fecha \_\_\_\_\_ para el Programa de Compra de Beneficios de Medicaid para Personas que Trabajan y están Incapacitadas(MBI-WPD) a partir del \_\_\_\_\_, para la(s) siguiente(s) persona(s) \_\_\_\_\_.

**Favor de revisar la hoja de datos del umbral de utilización del programa de Asistencia Médica que se encuentra en la sección de Asistencia Médica del folleto LDSS-4148B-SP titulado «Lo que usted debe saber sobre los programas de servicios sociales». Esta hoja le explica las limitaciones en los tipos de servicios. El folleto LDSS-4148B se le entregó cuando solicitó los servicios de asistencia.**

Esto debe a que su ingreso neto (ingresos brutos menos las deducciones de Asistencia Médica) por la cantidad de \$ \_\_\_\_\_ es igual o menor que la cantidad límite permitida por el programa de Compra de Beneficios de Medicaid para Personas que Trabajan y están Incapacitadas (MBI-WPD) cuyo límite es de \_\_\_\_\_ (250% del nivel de pobreza según lo establece el gobierno federal) y los recursos que se tomaron en cuenta por la cantidad de \$ \_\_\_\_\_ sobrepasan o llegan al límite de recursos de \$10,000.

Esto significa que usted puede afiliarse al programa del Estado de Nueva York de MBI-WPD, el cual le proporcionará cobertura de Asistencia Médica siempre y cuando:

- tenga un reconocimiento médico indicando su incapacidad; y
- esté trabajando; y
- tenga por lo menos 16 años de edad pero menos de 65; y
- tenga ingresos netos menores o igual al 250% del nivel de pobreza según lo establece el gobierno federal (FPL); y
- tenga recursos igual o menor a una cantidad de \$10,000; y
- cumpla con sus obligaciones en cuanto a los pagos de prima (de ser obligatorios).

**TOME NOTA: NO SE LE EXIGE UN PAGO DE PRIMA POR EL MOMENTO. SIN EMBARGO, EN EL 2004 EL ESTADO DE NUEVA YORK PONDRÁ EN MARCHA UN SISTEMA PARA LA RECOLECCIÓN DE LOS PAGOS DE PRIMA. SI SUS INGRESOS NETOS ESTÁN ENTRE EL 150% Y EL 250% DEL NIVEL DE POBREZA SEGÚN LO ESTABLECE EL GOBIERNO FEDERAL SE LE EXIGIRÁ PAGAR UNA PRIMA. CUANDO EL REQUISITO DEL PAGO DE PRIMA ENTRE EN VIGOR SE LE NOTIFICARÁ DE LA CANTIDAD DE LA PRIMA A PAGAR.**

Debido a que usted nos solicitó determinar si reúne las condiciones para recibir todos los cuidados y servicios que cubre Medicaid INCLUYENDO cuidados a largo plazo proveídos en la comunidad PERO NO los servicios de enfermería en centros de cuidados, no examinamos sus recursos de los últimos 36 meses (60 meses si se trata de un fideicomiso) y no tendrá cobertura por los siguientes servicios de enfermería:

- Cuidados de enfermería que se crea tengan una duración de por lo menos 30 días; o
- Cuidados de enfermería provistos en un hospital; o
- Cuidados de hospicio en centro de cuidados de enfermería; o
- Cuidados administrados de salud a largo plazo en un centro de cuidados de enfermería.

Si necesita cuidados de enfermería en un centro, comuníquese con su departamento local de Servicios Sociales. El personal de ese departamento examinará los recursos de los que ha dispuesto en los últimos 36 meses (60 si se trata de un fideicomiso) para determinar si reúne las condiciones para que Medicaid cubra estos servicios.

Hemos incluido una hoja(s) de cálculo de presupuesto de manera que usted pueda entender cómo hemos determinado los beneficios para los cuales usted reúne los requisitos.

La LEGISLACIÓN Y/O REGLAMENTO que nos permite tomar esta decisión es la Sección 366(1)(a)(12) y 367-a(12) de las leyes de Servicios Sociales.

**LEGISLACIÓN VIGENTE EXIGE QUE USTED NOTIFIQUE INMEDIATAMENTE A ESTE DEPARTAMENTO DE TODO CAMBIO EN SUS NECESIDADES, RECURSOS, SITUACIÓN DE VIVIENDA O DIRECCIÓN.**

**USTED TIENE EL DERECHO DE APELAR ESTA DECISIÓN.  
LEA EL REVERSO DE ESTE AVISO PARA MÁS INFORMACIÓN SOBRE CÓMO APELAR ESTA DECISIÓN.**

**DERECHO A UNA CONFERENCIA:** Usted puede pedir una conferencia para revisar estas acciones. Si desea una conferencia, le sugerimos solicitarla lo más pronto posible. Si durante la conferencia nos percatamos que nuestra decisión fue errónea, o en base a la información que usted proporcione, decidimos cambiar nuestra decisión; tomaremos acción correctiva y le proporcionaremos una nueva notificación. Puede solicitar una conferencia llamándonos al número que aparece en la primera página de esta notificación o enviándonos una solicitud a la dirección que aparece en la parte superior de la misma página. Este número es solamente para solicitar conferencias y **no es la manera de solicitar una audiencia imparcial**. Aunque solicite una conferencia, también tiene el derecho a una audiencia imparcial. Si desea que sus beneficios continúen sin cambios (asistencia ininterrumpida) a la espera de la decisión de la audiencia imparcial; debe solicitar una audiencia imparcial de la manera que se describe abajo. Lea a continuación la información sobre audiencias imparciales.

**DERECHO A UNA AUDIENCIA IMPARCIAL:** Si cree que la decisión antes mencionada es errónea, puede solicitar una audiencia estatal de la siguiente manera:

(1) **Por teléfono:** (FAVOR DE TENER A MANO ÉSTA NOTIFICACIÓN CUANDO LLAME)

(800) 342-3334

(2) **Por facsímil:** Envíe una copia de esta notificación al número de fax (518) 473-6735 ó

(3) **Por computadora:** Complete y envíe el formulario electrónico de petición en la siguiente dirección de Internet:

<https://www.otda.state.ny.us/oah/oahforms/erequestform.asp> ó

<http://www.otda.state.ny.us/oah/forms.asp> ó

(4) **Por escrito:** Envíe una copia de esta notificación **completamente rellena** a: Fair Hearing Section, New York State Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York 12201. Favor de quedarse con una copia.

Solicito una audiencia imparcial. La decisión de la agencia es errónea porque: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Nombre (en letra de molde): \_\_\_\_\_ No. de caso \_\_\_\_\_

Dirección: \_\_\_\_\_ Teléfono: \_\_\_\_\_

Firma del cliente: \_\_\_\_\_ Fecha: \_\_\_\_\_

**USTED TIENE 60 DÍAS A PARTIR DE LA FECHA DE ESTE AVISO PARA SOLICITAR UNA AUDIENCIA IMPARCIAL**

Si usted solicita una audiencia imparcial, el Estado le enviará una notificación informándole acerca de la hora y el lugar de la audiencia. Usted tiene el derecho de ser representado(a) por un abogado, un familiar, un amigo(a) u otra persona, o puede representarse a sí mismo(a). Durante la audiencia, usted, su abogado u otro representante tendrá la oportunidad de presentar pruebas orales y escritas para demostrar la razón por la cual la acción no debe llevarse a cabo, así como también la oportunidad de interrogar a toda persona que comparezca en la audiencia. También, tiene el derecho de presentar testigos que testifiquen en su favor. Se le sugiere presentar en la audiencia documentos tales como: esta notificación, talonarios de pagos salariales, recibos, cuentas médicas, cuentas de calefacción, verificación médica, cartas, etc., que puedan ayudarle en la presentación de su caso.

**CONTINUACIÓN DE SUS BENEFICIOS:** Si usted solicita una audiencia imparcial antes de la fecha de vigencia indicada en este aviso; continuará recibiendo sus beneficios como siempre hasta que se dé a conocer la decisión de la audiencia imparcial. No obstante, si no se decide a su favor en la decisión de la audiencia imparcial, nos podremos cobrar los beneficios de Asistencia Médica que usted recibió y a los cuales no tenía derecho. Si desea evitar esta situación, marque la casilla abajo indicando que usted no desea continuar recibiendo ayuda y envíe esta página junto con su petición de audiencia. Si usted marca la casilla, la acción descrita arriba será adoptada en la fecha de vigencia indicada arriba.

Estoy de acuerdo que se tome la decisión con respecto a mis beneficios de Asistencia Médica, según se describe en esta notificación, antes de darse a conocer la decisión de la audiencia imparcial.

**ASISTENCIA LEGAL:** Si usted necesita asistencia legal gratis, puede obtener tal ayuda comunicándose con la Sociedad de Ayuda Legal de su localidad (Legal Aid Society) u otro grupo legal de abogacía. Usted puede localizar la Sociedad de Ayuda Legal o el grupo de abogacía más cercano buscando en las Páginas Amarillas bajo "Abogados" ("Lawyers") o llamando al número que se indica en la primera página de esta notificación.

**ACCESO A SU ARCHIVO Y COPIAS DE DOCUMENTOS:** Para ayudarle a prepararse para la audiencia, se le otorga el derecho de examinar el archivo de su caso. Si nos llama por teléfono o nos manda una carta, le proporcionaremos copias gratis de los documentos de su archivo, los mismos que entregaremos al funcionario de audiencias en la audiencia imparcial. Así mismo, si usted nos llama por teléfono o nos manda una carta, le proporcionaremos copias gratis de otros documentos de su archivo que usted considere necesarios al prepararse para la audiencia imparcial. Para solicitar los documentos o para averiguar cómo examinar su archivo, llámenos al número de teléfono para Acceso a archivos que aparece en la parte superior de la página 1 de esta notificación o escribanos a la dirección impresa en la parte superior de esa misma página.

Si desea copias de los documentos en su archivo, debe pedirlos con anticipación. Se le entregarán en un plazo razonable antes de la fecha de la audiencia. Se le enviarán los documentos por correo solamente si usted específicamente lo solicita.

**INFORMACIÓN:** Si desea más información sobre su caso, cómo solicitar una audiencia imparcial, cómo examinar su archivo o cómo conseguir copias adicionales de documentos, llámenos a los números de teléfono indicados al comienzo de la página 1 de esta notificación o escribanos a la dirección impresa en esa misma página.

## CHILDHOOD DISABILITY EVALUATION FORM Medicaid Program

Name:	Case Number:	Date of Birth:
Agency:		
<input type="checkbox"/> New Case <span style="margin-left: 150px;"><input type="checkbox"/> Continuing Disability Review (CDR)</span>		
Reviewer Signature:		Date of Review:
Physician Signature:		

### I. SUMMARY

#### A. Impairments:

**B. Disposition:** Check one entry that best describes your findings in this case.  
Complete this section last.

- 1. Not Severe** - No medically determinable impairment OR impairment or combination of impairments is a slight abnormality or a combination of slight abnormalities that result in no more than minimal functional limitations.
- 2. Meets Listing** \_\_\_\_\_ (Cite listing and subsection).
- 3. Medically Equals Listing** \_\_\_\_\_ (Cite listing and subsection).
- 4. Functionally Equals The Listings** - The child's medically determinable impairment or combination of impairments results in marked limitations in two domains or an extreme limitation in one domain OR the impairment or combination of impairments is one of the examples cited in Section M. 6. (m) of the *Disability Manual*, example # \_\_\_\_\_.
- 5. Impairment Or Combination Of Impairments Is Severe, But Does Not Meet, Medically Equal Or Functionally Equal The Listings.**
- 6. Does Not Meet The Duration Requirement** - The child's medically determinable impairment(s) is or was of listing-level severity, but is not expected to be, or was not, of listing-level severity for 12 continuous months, and is not expected to result in death.
- 7. Other.** (Specify) \_\_\_\_\_

### **C. Assessment of Functioning Throughout Sequential Evaluation:**

#### **Factors to Consider:**

How the child's functioning compares to that of children the same age who do not have impairments; i.e., what the child is able to do, not able to do, or is limited or restricted in doing.

The combined effects of multiple impairments and the interactive and cumulative effects of an impairment(s) on the child's activities, considering that any activity may involve the integrated use of many abilities. So,

- A single limitation may be the result of one or more impairments, and

A single impairment may have effects in more than one domain.

How well the child performs activities with respect to:

- Initiating, sustaining, and completing activities independently (range of activities, prompting needed, pace of performance, effort needed, and how long the child is able to sustain activities);
  - Extra help needed (e.g. personal, equipment, medications);
  - Adaptations (e.g., assistive devices, appliances);
  - Structured or supportive settings (e.g., home, regular or special classroom), including comparison of functioning in and outside of setting, ongoing signs or symptoms despite setting, amount of support needed to function within regular setting.
4. Child's functioning in unusual settings, (e.g., one-to-one, a consultative exam) vs. routine settings (e.g., home, childcare, school).
  5. Early intervention and school programs (e.g., school records, comprehensive testing, individualized education plans, class placement, special education services, accommodations, attendance, participation).
  6. Impact of chronic illness, characterized by episodes of exacerbation and remission, and how it interferes with the child's activities over time.
  7. Effects of treatment, including adverse and beneficial effects of medications and other treatments, and if they interfere with the child's day-to-day functioning.

## II. FUNCTIONAL EQUIVALENCE

Consider functional equivalence when the child's medically determinable impairment(s) is "severe but does not meet or medically equal a listing. An impairment(s) functionally equals the listing if it results in "marked and severe functional limitations." i.e., the impairment(s) causes "marked" limitations in two domains or an "extreme" limitation in one domain.

Check one box for each domain to indicate the degree of limitation assessed.

### A. Domain Evaluations

---

---

#### 1. Acquiring and Using Information

No limitation       Less than Marked       Marked       Extreme

#### Attending and Completing Tasks

No Limitation       Less than Marked       Marked       Extreme

#### 3. Interacting and Relating with Others

No Limitation       Less than Marked       Marked       Extreme

#### 4. Moving About and Manipulating Objects

No Limitation       Less than Marked       Marked       Extreme

#### 5. Caring For Yourself

No Limitation       Less than Marked       Marked       Extreme

#### 6. Health and Physical Well-Being

No Limitation       Less than Marked       Marked       Extreme

## B. Conclusion

### Does the impairment or combination of impairments functionally equal the listings?

#### Marked Limitation

Yes - Marked limitation in two domains.

The impairment(s) **interferes seriously** with the child's ability to independently initiate, sustain, or complete domain-related activities. Day-to-day functioning may be seriously limited when the child's impairment(s) limit only one activity or when the interactive and cumulative effects of the child's impairment(s) limit several activities.

"More than moderate" but "less than extreme" limitation (i.e., the equivalent of functioning we would expect to find on standardized testing with scores that are at least two, but less than three, standard deviations below the mean), or

Up to attainment of age 3, functioning at a level that is more than one-half but not more than two-thirds of the child's chronological age when there are no standard scores from standardized tests in the case record, or

At any age, a valid score that is two standard deviations or more below the mean, but less than three standard deviations, on a comprehensive standardized test designed to measure ability or functioning in that domain, and the child's day-to-day functioning in domain-related activities is consistent with that score.

For the "*Health and Physical Well-Being*" domain, a child may have a "marked" limitation if the child is frequently ill or has frequent exacerbations that result in significant, documented symptoms or signs. For purposes of this domain, "frequent" means episodes of illness or exacerbations that occur on an average of 3 times a year or once every 4 months, each lasting 2 weeks or more. We may also find a "marked" limitation if the child has episodes that:

- occur more often than 3 times in a year or once every 4 months but do not last for 2 weeks, or
- occur less often than an average of 3 times a year or once every 4 months but last longer than 2 weeks, if the overall effect (based on the length of the episode(s) or its frequency) is equivalent in severity.

## Extreme limitation

- Yes - Extreme limitation in one domain.

The impairment(s) **interferes very seriously** with the child's ability to independently initiate, sustain, or complete domain-related activities. Day-to-day functioning may be very seriously limited when the child's impairment(s) limits only one activity or when the interactive and cumulative effects of the child's impairment(s) limit several activities. "Extreme" describes the worst limitations, but does not necessarily mean a total lack or loss of ability to function.

"More than marked" limitation (i.e., the equivalent of the functioning a child might have on standardized testing with scores that are at least three standard deviations below the mean), or

- Up to the attainment of age 3, functioning at a level that is one-half of the child's chronological age less when there are no standard scores from standardized tests in the case record, or

At any age, a valid score that is three standard deviations or more below the mean on a comprehensive standardized test designed to measure ability or functioning in that domain, and the child's day-to-day functioning in domain-related activities is consistent with that score.

For the *"Health and Physical Well-Being"* domain a child may have an "extreme" limitation if the child is ill or has frequent exacerbations that result in significant, documented symptoms or signs substantial excess of the requirements for showing a "marked" limitation. However, if the child has episodes of illness or exacerbations of the impairment(s) that would be rated as "extreme" under this definition, the impairment(s) should meet or medically equal the requirements of a listing in most cases.

- No - The impairment or combination of impairments does not functionally equal the listings.

## MEDICAL REPORT FOR DETERMINATION OF DISABILITY

Pages 1 and 2 **MUST** be completed in their entirety by ALL providers.  
 Subsequent pages must be completed **only** on the basis of impairment.

NEW YORK STATE Please type or print clearly DEPARTMENT OF SOCIAL SERVICES

### SECTION I - IDENTIFICATION (To Be Completed by Submitting Agency)

AGENCY'S NAME AND ADDRESS	PATIENT'S NAME (Last, First, Middle)	CASE NUMBER	
		SOCIAL SECURITY NUMBER	
	PATIENT'S ADDRESS	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH
	CITY STATE ZIP CODE		

### SECTION II - MEDICAL REPORT

**MESSAGE TO PHYSICIAN**

As patient has made application (reapplication) for Disability Medicaid. Your cooperation in completing the form to show the patient's current condition, focusing on both limitations and remaining capabilities, is requested. Your promptness will insure an early decision on the patient's application. **Please return completed form to the agency in Section I above.**

DATE OF EXAMINATION	1. DIAGNOSIS(ES)
CURRENT MEDICATIONS AND DOSAGES	

**GENERAL FINDINGS:**

Height  _____ Ft. _____ In.	Weight  _____ Lbs.	Blood Pressure
-----------------------------------	--------------------------	----------------

**PATIENT COMPLIANCE** Has patient demonstrated compliance with medical treatment?  Yes  No If "No", please state reason. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**BODY SYSTEMS** Please indicate if the systems listed below are "normal"/"abnormal" or "present"/"absent". ("Abnormal" or "present" means patient's complaint, objective physical finding or atypical diagnostic test.) Where "abnormal"/"present" body systems are indicated, please complete the appropriate body system section in detail or submit a summary of your records which contain the required information. Please include operative notes if surgical procedures have been performed.

SYSTEM	NORMAL	ABNORMAL	SYSTEM	NORMAL	ABNORMAL
Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/> See Pg. 3-8	Skin	<input type="checkbox"/>	<input type="checkbox"/> See Pg. 19
Special Senses and Speech	<input type="checkbox"/>	<input type="checkbox"/> See Pg. 9-12	Endocrine	<input type="checkbox"/>	<input type="checkbox"/> See Pg. 19
Respiratory	<input type="checkbox"/>	<input type="checkbox"/> See Pg. 13-14	Multiple Body	<input type="checkbox"/>	<input type="checkbox"/> See Pg. 20
Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/> See Pg. 15-16	Neurological	<input type="checkbox"/>	<input type="checkbox"/> See Pg. 21
Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/> See Pg. 17		<b>PRESENT</b>	<b>ABSENT</b>
Genito-Urinary	<input type="checkbox"/>	<input type="checkbox"/> See Pg. 18	Mental Disorders	<input type="checkbox"/>	<input type="checkbox"/> See Pg. 22-24
Immune and Lymphatic	<input type="checkbox"/>	<input type="checkbox"/> See Pg. 18	Neoplastic Diseases, Malignant	<input type="checkbox"/>	<input type="checkbox"/> See Pg. 25

**FUNCTIONAL CAPACITY**

<b>CHART 1 - EXERTIONAL FUNCTIONS</b>					
Please indicate ranges of physical exertion possible below by circling the appropriate areas for this patient.					
RANGES OF PHYSICAL EXERTION					
	HEAVY	MEDIUM	LIGHT	SEDENTARY	LESS THAN SEDENTARY
Lifting	100 lbs. occ. 50 lbs. freq.	50 lbs. occ. 25 lbs. freq.	20 lbs. occ. 10 lbs. freq.	10 lbs/occ.	< 10 lbs. occ.
Standing and/or Walking	6 hrs/day min.	6 hrs/day min.	6 hrs/day min.	2 hrs/day	< 2 hrs/day
	6 hrs/day min.	6 hrs/day min.	6 hrs/day min.	2 hrs/day	< 2 hrs/day
Pushing/Pulling	N/A	N/A	Arm and/or leg controls	N/A	N/A
Sitting	N/A	N/A	N/A	6 hrs/day	< 6 hrs/day

**CHART 2 - NON-EXERTIONAL FUNCTIONS**  
Please indicate if the below indicated functions are normal or abnormal. If abnormal, please explain limitation in the space provided.

<b>SENSORY</b>	NORMAL	ABNORMAL	EXPLANATION
Seeing/Hearing	<input type="checkbox"/>	<input type="checkbox"/>	
Speaking	<input type="checkbox"/>	<input type="checkbox"/>	
<b>POSTURAL</b>	NORMAL	ABNORMAL	EXPLANATION
Repetitive stooping and bending for long periods	<input type="checkbox"/>	<input type="checkbox"/>	
Remaining seated for long periods	<input type="checkbox"/>	<input type="checkbox"/>	
Crouching or Squatting	<input type="checkbox"/>	<input type="checkbox"/>	
Climbing	<input type="checkbox"/>	<input type="checkbox"/>	
<b>MENTAL</b>	NORMAL	ABNORMAL	EXPLANATION
Understanding, carrying out and remembering instructions	<input type="checkbox"/>	<input type="checkbox"/>	
Responding appropriately to co-workers and to supervision	<input type="checkbox"/>	<input type="checkbox"/>	
Meeting quality standards and production norms	<input type="checkbox"/>	<input type="checkbox"/>	
Sustaining adequate attendance	<input type="checkbox"/>	<input type="checkbox"/>	
<b>MANIPULATIVE</b>	NORMAL	ABNORMAL	EXPLANATION
Grasping, releasing, handling and fingering objects	<input type="checkbox"/>	<input type="checkbox"/>	
<b>ENVIRONMENTAL</b>	NORMAL	ABNORMAL	EXPLANATION
Tolerating dust, fumes extremes of temperature	<input type="checkbox"/>	<input type="checkbox"/>	
Tolerating exposure to heights or machinery	<input type="checkbox"/>	<input type="checkbox"/>	
Operating a motor vehicle	<input type="checkbox"/>	<input type="checkbox"/>	

<b>EXAMINING PHYSICIAN</b>			
SIGNATURE	(PRINT NAME)	DATE SIGNED	
<u>X</u>	M.D.	M.D.	
SPECIALTY, IF ANY	BOARD CERTIFIED	BOARD ELIGIBLE	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
OFFICE ADDRESS	OFFICE TELEPHONE NUMBER		

# MUSCULOSKELETAL MEDICAL REPORT

Patient's Name \_\_\_\_\_ SSN \_\_\_\_\_

1. **Diagnosis** \_\_\_\_\_
2. **Dates of Treatment** First \_\_\_\_\_ Last \_\_\_\_\_ Frequency \_\_\_\_\_
3. **History and Subsequent Course** Include date and description of earliest symptoms; any history of trauma or joint inflammation, sensory, motor or reflex deficits.

## 4. Findings on Last Examination With Date

a. Please describe any current findings including presence or absence of muscle spasm, sensory, motor or reflex deficits (including sites), with measurement of atrophy of both affected and unaffected extremity at same level for comparison and any swelling, heat or tenderness. List presence and describe location and severity of any contracture, ankylosis or subluxation.

b. Please indicate current limitations of motion in involved joints, with date of exam, using the attached "Range of Motion Chart".

## 5. Fractures

a. If recent fracture(s) present, give date of occurrence, x-ray report findings, treatment course.

b. Is there clinical union?     Yes             No

c. Expected date of full weight bearing \_\_\_\_\_ If ambulatory, how far can patient ambulate?  
Is improvement expected? \_\_\_\_\_

d. Upper extremity -- expected date of restored functional use \_\_\_\_\_

**MUSCULOSKELETAL MEDICAL REPORT (continued)**

**Patient's Name**

**SSN**

**6. Laboratory Findings**

Laboratory findings including dates and results of serological test; e.g., rheumatoid factors, sedimentation rate, antinuclear antibodies, specific findings on x-ray (or a copy of report), enzyme studies, biopsies, and nerve conduction studies.

**7. Treatment**

Please give treatment including type, date and results of any surgery performed, current medication with dosage and frequency.

**8. Orthotics**

If an orthotic appliance is being worn, describe and give indication for use and its efficacy

**9. Ambulatory Aides**

Does the patient require a cane, walker or wheelchair?

## MUSCULOSKELETAL MEDICAL REPORT

### Spinal Disorders

Patient's Name \_\_\_\_\_

SSN \_\_\_\_\_

1. Diagnosis \_\_\_\_\_

2. Dates of Treatment

First \_\_\_\_\_

Last \_\_\_\_\_

Frequency \_\_\_\_\_

3. History and Current Findings

a. Date of first symptoms; inciting factor(s); description of character; location and radiation of pain.

b. Pertinent physical findings

(1) Site and severity of any sensory, motor, or reflex abnormalities.

(2) Please indicate limitation of movement of the spine on the attached "Range of Motion Chart"

(3) Any atrophy including actual circumferential measurements at a stated point above and below the knee or elbow given in inches or centimeters.

4. Lab Values

Laboratory findings, including dates and specific findings on x-ray (or copy of report), myelogram, or electro-diagnostic testing.

**MUSCULOSKELETAL MEDICAL REPORT**

**Spinal Disorders** (continued)

**Patient's Name**

**SSN**

**5. Treatment**

Treatment including date, nature and result of any surgical procedure (please include copies of operative and pathology reports); medications prescribed with dosage, frequency and response.

**6. Observation**

Results of verifying observation (e.g., how patient gets on and off examining table, whether results of SLR are consistent in other positions such as sitting, ability to walk on heels or toes, arise from squatting position, etc.).

## RANGE OF MOTION CHART

Patient's Name \_\_\_\_\_ SSN \_\_\_\_\_

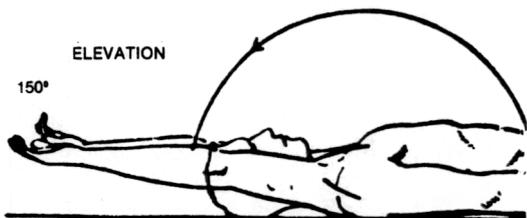
Diagnosis \_\_\_\_\_

Please complete **ONLY** the sections of this chart which illustrate joints that have less than full range of motion. Proceed by filling in the degree at which motion stops. Sections left blank will be considered normal.

### SHOULDER

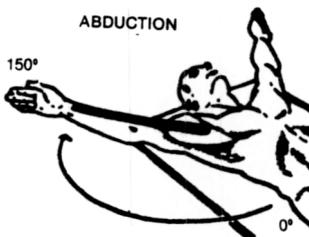
A. Forward Elevation (0°-150°)

Right \_\_\_\_\_ Left \_\_\_\_\_



B. Abduction (0°-150°)

Right \_\_\_\_\_ Left \_\_\_\_\_



C. Adduction (0°-30°)

Right \_\_\_\_\_ Left \_\_\_\_\_

D. Internal Rotation (0°-40°)

Right \_\_\_\_\_ Left \_\_\_\_\_

E. External Rotation (0°-90°)

Right \_\_\_\_\_ Left \_\_\_\_\_

### ELBOW

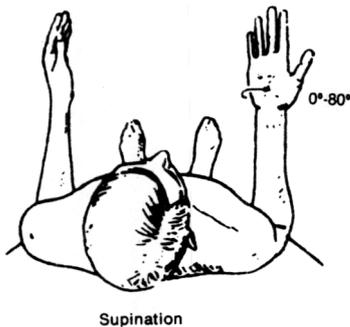
A. Flexion-Extension (0°-150°)

Right \_\_\_\_\_ Left \_\_\_\_\_



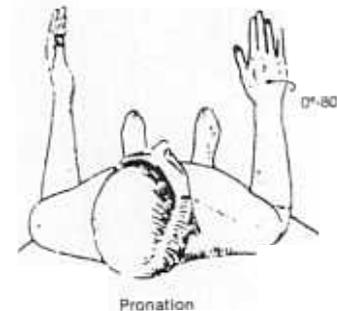
B. Supination (0°-80°)

Right \_\_\_\_\_ Left \_\_\_\_\_



C. Pronation (0°-80°)

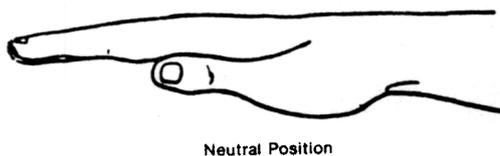
Right \_\_\_\_\_ Left \_\_\_\_\_



### WRIST

A. Dorsiflexion (0°-60°)

Right \_\_\_\_\_ Left \_\_\_\_\_



B. Palmar Flexion (0°-70°)

Right \_\_\_\_\_ Left \_\_\_\_\_

C. Radial Deviation (0°-20°)

Right \_\_\_\_\_ Left \_\_\_\_\_

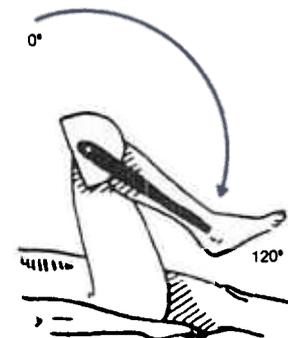
D. Ulnar Deviation (0°-30°)

Right \_\_\_\_\_ Left \_\_\_\_\_

### KNEE

A. Flexion-Extension (0°-120°)

Right \_\_\_\_\_ Left \_\_\_\_\_



RANGE OF MOTION CHART (Continued)

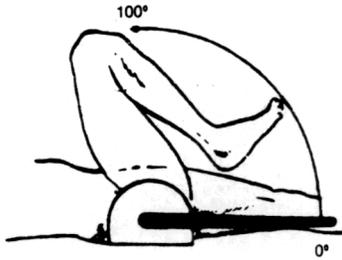
Patient's Name \_\_\_\_\_

SSN \_\_\_\_\_

HIP

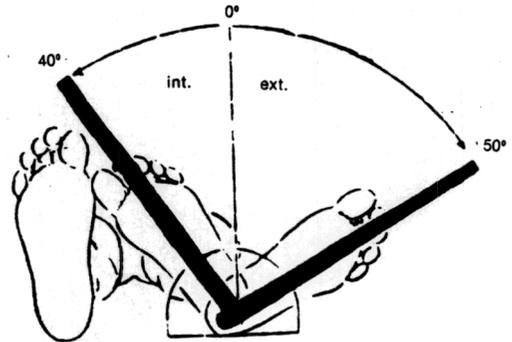
A. Forward Flexion (0°-100°)

Right \_\_\_\_\_ Left \_\_\_\_\_



C. Rotation-Interior (0°-40°)

Right \_\_\_\_\_ Left \_\_\_\_\_



Rotation-Exterior (0°-50°)

Right \_\_\_\_\_ Left \_\_\_\_\_

B. Backward Extension (0°-30°)

Right \_\_\_\_\_ Left \_\_\_\_\_

D. Abduction (0°-40°)

Right \_\_\_\_\_ Left \_\_\_\_\_

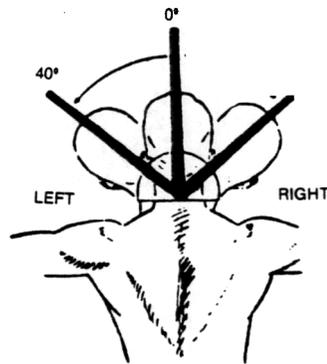
E. Adduction (0°-20°)

Right \_\_\_\_\_ Left \_\_\_\_\_

SPINE (Cervical Region)

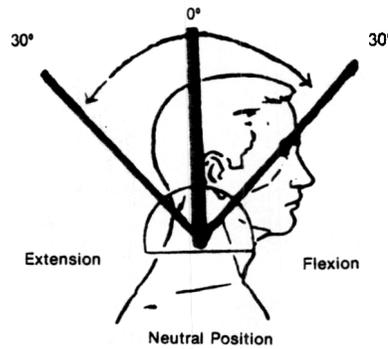
A. Lateral Flexion (0°-40°)

Right \_\_\_\_\_ Left \_\_\_\_\_



B. Flexion (0°-30°)

C. Extension (0° - 30°)



D. Rotation (0°-45°)

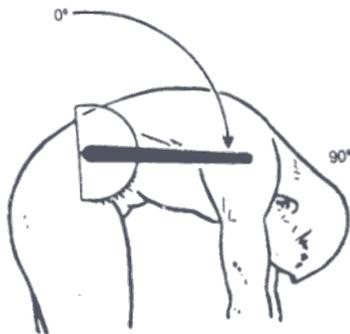
Right \_\_\_\_\_ Left \_\_\_\_\_



SPINE (Lumbar Region)

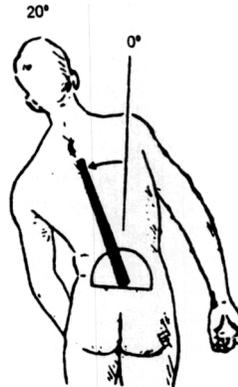
A. Flexion-Extension (0°-90°)

\_\_\_\_\_



B. Lateral Flexion (0°-20°)

Right \_\_\_\_\_ Left \_\_\_\_\_

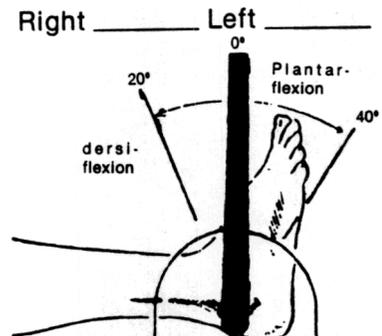


ANKLE

A. Dorsi-Flexion (0°-20°)

Right \_\_\_\_\_ Left \_\_\_\_\_

Plantar-Flexion (0°-40°)



### VISUAL MEDICAL REPORT

Patient's Name \_\_\_\_\_ SSN \_\_\_\_\_

Diagnosis	Right Eye	Left Eye
	_____	
	_____	

2. Dates of Treatment First \_\_\_\_\_ Last \_\_\_\_\_ Frequency \_\_\_\_\_

3. History:

a Etiology of impairment and signs and symptoms on first visit	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____

b. Central visual acuity on first visit		
1 Distant vision without correction	_____	_____
2 Distant vision with best correction	_____	_____
3 Near vision using Jaeger notation	_____	_____
c. Tension	_____	_____

4. Please give treatment and response, including dates, description, and residuals of any surgical procedures.

**VISUAL MEDICAL REPORT (continued)**

Patient's Name \_\_\_\_\_ SSN \_\_\_\_\_

**5. Current Findings**

**Right Eye**

**Left Eye**

a. Current signs and symptoms


b. Central visual acuity Date \_\_\_\_\_

(1) Distant vision without correction \_\_\_\_\_

(2) Distant vision with best correction \_\_\_\_\_  
(include power of correcting lenses)

(3) Near vision using Jaeger notation \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

c. Tension

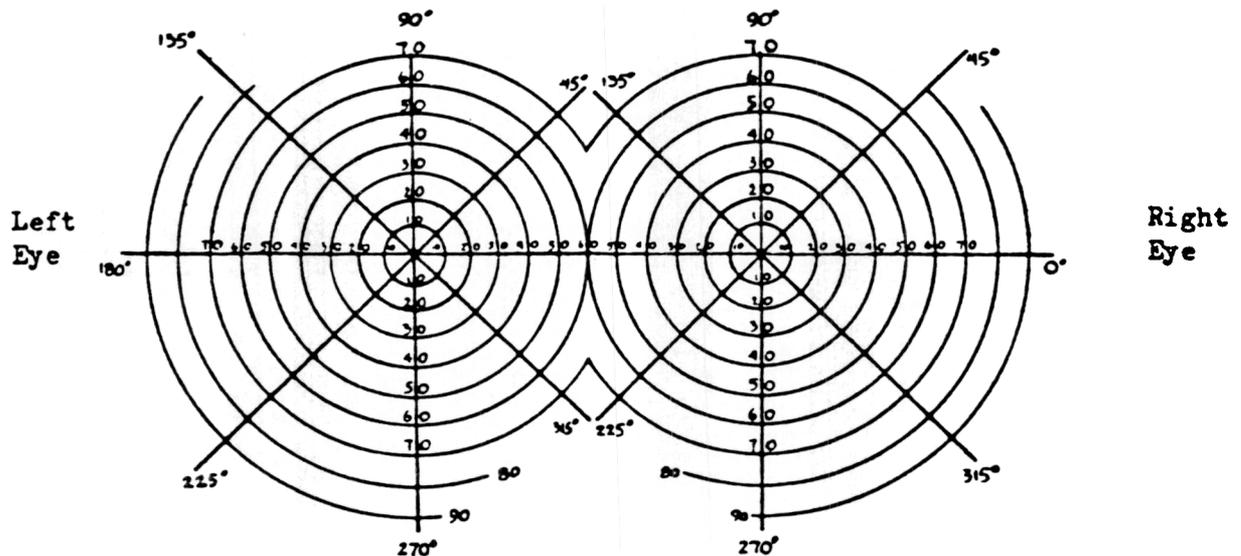
d. If best corrected vision in both eyes is 20/200 or less, specify earliest date of this finding. \_\_\_\_\_

e. If visual field is constricted to 10° or less from the point of fixation, or the widest angle subtended to 20° or less, specify earliest date of this finding. \_\_\_\_\_

**6. Please enclose a copy of results of peripheral visual field testing by arc perimetry or Goldmann projection perimetry or complete the chart below.**

a. Date of testing \_\_\_\_\_ b. Type and size of target \_\_\_\_\_

c. Test distance \_\_\_\_\_ d. Illumination \_\_\_\_\_ e. Corrective lenses used  Yes  No



### HEARING IMPAIRMENT MEDICAL REPORT

Patient's Name \_\_\_\_\_ SSN \_\_\_\_\_

- 1. Diagnosis \_\_\_\_\_
- 2. Dates of Treatment First \_\_\_\_\_ Last \_\_\_\_\_ Frequency \_\_\_\_\_
- 3. Please give findings on initial and most recent otolaryngological examination.

4. Please give results of pure-tone air and bone audiometry requested below. Please include the audiogram or a copy of it.

Tested by  Audiologist  
 Otolaryngologist

a. Audiometer used \_\_\_\_\_

b. Results in decibels at the following frequencies:

Left Ear

Right Ear

500 HZ \_\_\_\_\_

2. 1000 HZ \_\_\_\_\_

3. 2000 HZ \_\_\_\_\_

5. Please give results of speech discrimination testing with best correction

a. Test used \_\_\_\_\_

b. Percentage score \_\_\_\_\_

c. Decibel level at which testing was done \_\_\_\_\_ db.

d. Speech reception threshold

1. Left \_\_\_\_\_ db.

2. Right \_\_\_\_\_ db.

e. Results of tympanometry

Hearing aid evaluation

HEARING IMPAIRMENT MEDICAL REPORT (continued)

Patient's Name \_\_\_\_\_ SSN \_\_\_\_\_

6. Please give pertinent laboratory and x-ray findings. In cases of labyrinthine-vestibular disturbance, please give positional and caloric testing, electronystagmography, if performed.

7. In cases involving labyrinthine-vestibular disturbance, please answer the following:

a. Is vertigo present?       No       Yes      If yes, give:

1. Frequency of attacks \_\_\_\_\_

2. Severity of attacks \_\_\_\_\_

3. Duration of attacks \_\_\_\_\_

4. Activities which precipitate attacks \_\_\_\_\_

\_\_\_\_\_

b. Is there tinnitus?       No       Yes      Frequency \_\_\_\_\_

c. Is gait affected?       No       Yes      Describe \_\_\_\_\_

\_\_\_\_\_

d. Other symptoms (e.g., headaches, nausea and vomiting, syncope, increased deafness, immobility, etc.)

8. Is there evidence of speech impairment?      If yes, please describe.

9. Please indicate treatment plan and response.

## RESPIRATORY MEDICAL REPORT

Patient's Name \_\_\_\_\_ SSN \_\_\_\_\_

1. Diagnosis \_\_\_\_\_

2. Dates of Treatment First \_\_\_\_\_ Last \_\_\_\_\_ Frequency \_\_\_\_\_

3. **History.** Include date and description of earliest symptoms (e.g., dyspnea, cough, hemoptysis, weight loss, etc.), and the nature, frequency and duration of episodes of respiratory distress. Include number of acute episodes which have occurred in the past year (with dates) requiring intensive hospital or emergency room care with intravenous or inhalation therapy.

### 4. Physical Findings

a. Date of Exam \_\_\_\_\_ b. Height \_\_\_\_\_ c. Weight \_\_\_\_\_

d. Findings on examination (e.g., presence of wheezing, rales, rhonchi, cyanosis, clubbing, edema of extremities, etc.)

e. Please indicate degree of orthopnea. How many blocks can patient walk or flights of stairs climb without dyspnea?

**RESPIRATORY MEDICAL REPORT** (continued)

**Patient's Name** \_\_\_\_\_

**SSN** \_\_\_\_\_

**5. Laboratory Findings with Dates**

Has client had PFT done?     No     Yes    If yes, please submit copy or give values as indicated below.

a. Results of ventilatory studies (FEV-1, MVV, VC) before and after bronchodilators or copy of report. Please enclose actual spirographic tracings, and comment upon patient's cooperation.

b. Results of chest x-ray, bronchoscopy, blood gas studies (arterial PCO<sub>2</sub> and PO<sub>2</sub>)

**6. Please give treatment response**

a. Date and description of any surgical procedure(s) with results

b. Names and dosages of any medications prescribed including dates prescribed and if patient still on prescribed medication

**CARDIOVASCULAR MEDICAL REPORT**

**Patient's Name** \_\_\_\_\_ **SSN** \_\_\_\_\_

1. **Diagnosis** \_\_\_\_\_

2. **Dates of Treatment** First \_\_\_\_\_ Last \_\_\_\_\_ Frequency \_\_\_\_\_

Please give history including initial symptoms with dates first experienced, associated findings, present symptoms; diagnosis (with AMA classification if possible).

**3. Description of Chest Pain**

a. **Location of pain** \_\_\_\_\_

\_\_\_\_\_

b. **Characteristics of pain (e.g., burning, crushing, sticking)** \_\_\_\_\_

\_\_\_\_\_

c. **Site(s) of any radiation of pain** \_\_\_\_\_

\_\_\_\_\_

d. **What precipitates pain** \_\_\_\_\_

\_\_\_\_\_

e. **How pain is relieved** \_\_\_\_\_

\_\_\_\_\_

f. **Duration of episodes** \_\_\_\_\_

\_\_\_\_\_

g. **Frequency of episodes** \_\_\_\_\_

\_\_\_\_\_

h. **Is patient awakened from sleep because of pain?**



## DIGESTIVE MEDICAL REPORT

Patient's Name \_\_\_\_\_

SSN \_\_\_\_\_

1. **Diagnosis** \_\_\_\_\_
2. **Dates of Treatment** First \_\_\_\_\_ Last \_\_\_\_\_ Frequency \_\_\_\_\_
3. **Please indicate if recurrent upper GI hemorrhage is evident, with etiology. Please indicate dates and results of repeated hematocrits.**
  
4. **If peptic ulcer disease is evident, please indicate what has been demonstrated by x-ray or endoscopy.**
  
5. **If weight loss has occurred, please describe pattern.**
  
6. **If chronic liver disease is evident, please indicate what procedures have been done. Please indicate bilirubin X 5 month period.**
  
7. **If chronic colitis or regional enteritis are present, please give history, including operative findings, barium studies, biopsy, endoscopy report findings. Please indicate dates and results of repeated hematocrits. Indicate frequency of episodes of diarrhea, dehydration, pain and hospitalizations. If patient is being treated medically, please indicate medications. If being treated with Prednisone, indicate dosage and frequency.**
  
8. **Please give any pertinent lab data not included above.**

## GENITO-URINARY MEDICAL REPORT

Patient's Name \_\_\_\_\_ SSN \_\_\_\_\_

1. Diagnosis \_\_\_\_\_
2. Dates of Treatment First \_\_\_\_\_ Last \_\_\_\_\_ Frequency \_\_\_\_\_
3. Please indicate if there is impairment of renal function including history of dialysis (acute or chronic) with frequency, transplant procedure report with post-op status report, serum creatinine for three month period. Is nephrotic syndrome present? Please indicate serum albumin and proteinuria.
  
4. Please indicate if anorexia exists and describe weight loss pattern.

---

## HEMIC AND LYMPHATIC MEDICAL REPORT

Patient's Name \_\_\_\_\_ SSN \_\_\_\_\_

1. Diagnosis \_\_\_\_\_
2. Dates of Treatment First \_\_\_\_\_ Last \_\_\_\_\_ Frequency \_\_\_\_\_  
Please indicate chemotherapeutic treatment regimen.
3. History and Current Findings
  - a. In cases of chronic leukemia, chronic anemia, macroglobulinemia or heavy chain disease, please indicate hematocrit values from date of diagnosis forward.
  
  - b. In cases of chronic anemia, chronic thrombocytopenia, hereditary telangiectasia, coagulation defects, chronic leukemia, macroglobulinemia, please indicate transfusion history.
  
  - c. If any other cases of hemic or lymphatic disorders exist, please give history and lab values from diagnosis date forward.

### SKIN DISORDERS MEDICAL REPORT

Patient's Name \_\_\_\_\_ SSN \_\_\_\_\_

1. Diagnosis \_\_\_\_\_

2. Dates of Treatment First \_\_\_\_\_ Last \_\_\_\_\_ Frequency \_\_\_\_\_

3. History and Current Findings

4. Please indicate prognosis

---

### ENDOCRINE MEDICAL REPORT

Patient's Name \_\_\_\_\_ SSN \_\_\_\_\_

1. Diagnosis \_\_\_\_\_

2. Dates of Treatment First \_\_\_\_\_ Last \_\_\_\_\_ Frequency \_\_\_\_\_

3. History and Current Findings

a In cases of diabetes, please give complete history of episodes of acidosis, neuropathy, retinopathy and amputation

b. For all other endocrine disorders, please include diagnostic results and course to date.

## MULTIPLE BODY SYSTEMS MEDICAL REPORT

Patient's Name \_\_\_\_\_

SSN \_\_\_\_\_

1. Diagnosis \_\_\_\_\_

2. Dates of Treatment First \_\_\_\_\_ Last \_\_\_\_\_ Frequency \_\_\_\_\_

3. History and Current Findings

Please indicate the history and current findings regarding the following diagnoses: Hansen's disease; polyarteritis or periarteritis nodosa; systemic lupus erythematosus; scleroderma or progressive systemic sclerosis; obesity. Please include lab values and in cases of obesity, please indicate the following: weight hx, hx pain and limitation of ROM with x-ray reports, blood pressure readings, cardiac status if abnormal, pulmonary function studies if respiratory status is abnormal.

**NEUROLOGICAL MEDICAL REPORT**

**Patient's Name** \_\_\_\_\_ **SSN** \_\_\_\_\_

1. **Diagnosis** \_\_\_\_\_
2. **Dates of Treatment** First \_\_\_\_\_ Last \_\_\_\_\_ Frequency \_\_\_\_\_
3. **Please give original chief complaint with initial history and findings.**
  
4. **Please describe subsequent course, including dates and details of any hospitalizations; give treatment with date started response, any surgical procedures performed, medications with dosages.**
  
5. **Please give detailed findings on last examination including site and severity of any sensory, motor, reflex, cerebellar, proprioceptive or cranial nerve deficits. Describe the effect upon gait, station, gross and dexterous movements. Are there any difficulties with communication?**
  
6. **Please give dates and results of significant laboratory findings (e.g., EEG, LP, brain scan, CAT scan, x-ray or pathology reports, angiogram, etc.); if possible, please append copies of reports.**
  
7. **Please indicate prognosis.**



**PSYCHIATRIC MEDICAL REPORT (continued)**

**Patient's Name** \_\_\_\_\_

**SSN** \_\_\_\_\_

**d. Sensorium and intellectual functions**

- attention and concentration
- orientation
- memory
- information
- ability to perform calculations, serial sevens, etc.

**e. Insight and judgment**

**5. Please provide the results of any special testing performed (EEG, psychometric tests, etc.) as well as any information you may have concerning other medical impairments.**

**6. Current Functional Assessment**

a. Activities of daily living (Please include a full description of how the patient spends a typical day with specific examples of grooming and hygiene, maintenance of residence, shopping, cooking, taking public transportation, interests and hobbies, etc.)

b. Social functioning (Please include a full description with specific examples of capacity to interact appropriately and communicate effectively with family members, friends, neighbors, etc.)

PSYCHIATRIC MEDICAL REPORT (continued)

Patient's Name \_\_\_\_\_ SSN \_\_\_\_\_

7 **Ability to Function in a Work Setting.** Please describe in detail any difficulties in work or work-like settings (e.g. volunteer work, workshops, service in community groups), especially with regard to relationships with supervisor, relationships with peers and performance of job duties, (e.g., capacity to understand, carry out and remember instructions).

8. If suicidal features are present, describe in detail, and include whatever management steps have been taken.

9. Other Comments

Patient's Name \_\_\_\_\_ SSN \_\_\_\_\_

1. Cancer Diagnosis \_\_\_\_\_

a. Staging of primary tumor and location of metastasis \_\_\_\_\_  
\_\_\_\_\_

2. Treatment

a. Surgical - Give date of surgery, type and result \_\_\_\_\_  
\_\_\_\_\_

b. Non-Surgical     Hormonal                       Chemotherapy                       Radiation  
                          Other (specify) \_\_\_\_\_

(1) Intention     Curative                       Palliative

(2) Treatment Plan

a. Date initiated \_\_\_\_\_

b. Specifics - type(s), dosages and frequency administration of agents being used in therapy  
\_\_\_\_\_

c. Route given \_\_\_\_\_

d. Expected duration of each mode of therapy \_\_\_\_\_  
\_\_\_\_\_

c. Please indicate life expectancy of patient \_\_\_\_\_

3. Describe any adverse effects of therapy and extent to which it limits patient \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Patient's Present Status

Date Last Seen \_\_\_\_\_

- No evidence of disease
- Disease present but not progressing
- Disease not controlled
- Other Comments \_\_\_\_\_

a. Give present clinical and/or laboratory findings \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Give any other diagnoses known with the clinical and laboratory findings available \_\_\_\_\_  
\_\_\_\_\_

6. Some advanced lesions are found to be surgically resectable after initial non-surgical therapy is given. If this is or was the case, or if there are any other unusual aspects, please describe \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



## INSTRUCTIONS

### Disability Review Team Certificate

#### 1. Agency Instructions

Items 1 (Case Number), 2 (Case Name), 4 (Client I.D.#) and 5 (Name of Agency) are to be completed by the appropriate local district worker.

#### 2. Review Team Instructions

Item 3 (Expiration Date).

Enter the expiration date if the case has been classified as Group II. The initial time interval shall be no less than one year from the effective date of the disability (indicated in Item 9). However, the Disability Review Team may request that additional data or a progress report be submitted at any time during such twelve-month period. Group I cases do not have to be submitted for further eligibility determination unless the factors of medical or social eligibility change.

Item 6 (Date of Review).

Enter the date the Review Team made the present determination.

Item 7 (Diagnosis).

Enter the primary and any other diagnoses being considered by the Disability Review Team.

Item 8 (Review Team's Determination).

Indicate whether a case is "Approved", "Disapproved", or "No Action". If approved, indicate whether the case is Group I or Group II. If the case is a "No Action", indicate whether the medical and/or social data is inadequate.

Item 9 (Effective Date of Disability).

Enter the effective date of medical disability established by the Review Team. (See Department Regulations 360.40 as reflected in the MA Disability Manual for instructions.)

Item 10 (Request for Additional Data or Reasons for Determination).

This section must be completed in all cases to demonstrate the reason(s) for the determination. Regulatory citations such as, specific listing of impairment(s) evaluated, the client's residual functional capacity and applicable medical/vocational considerations or failure to meet durational requirement must be detailed in this section to indicate a rationale for the Review Team's decision. If any medical and/or social evidence is lacking in the record in order to make a determination, it should be indicated. Further, if specific documentation is needed for recertification for Group II cases, it should be noted.

Item 11 (Signature of Reviewing Physician) and Item 12 (Signature of Reviewing Social Worker).

The reviewing physician and reviewing social worker sign names in full.





5. HAVE YOU SEEN ANY OTHER DOCTORS FOR YOUR IMPAIRMENTS?  YES  NO

NAME	ADDRESS	
TELEPHONE NUMBER (include area code) ( )		
HOW OFTEN DO YOU SEE THIS DOCTOR?	DATE YOU FIRST SAW THIS DOCTOR.	DATE YOU LAST SAW THIS DOCTOR.
REASONS AND TREATMENT (If different than in 4 above.)		

6. HAVE YOU BEEN TREATED BY ANY OTHER DOCTORS FOR YOUR IMPAIRMENTS?  YES  NO (If Yes complete DSS-1151.1 - Continuation Sheet)

7. HAVE YOU BEEN HOSPITALIZED OR TREATED AT A CLINIC FOR YOUR IMPAIRMENTS?  YES  NO

NAME OF HOSPITAL OR CLINIC	ADDRESS	
PATIENT OR CLINIC NUMBER		
CONTACT PERSON	POSITION	
WERE YOU AN INPATIENT? (Stayed at least overnight?) <input type="checkbox"/> YES <input type="checkbox"/> NO (If Yes, indicate admission and discharge dates.)		
WERE YOU AN OUTPATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO (If Yes, indicate dates of visits.)		
REASON FOR HOSPITALIZATION OR CLINIC VISITS (State illness or injury for which you had an examination or treatment.)		
TYPE OF TREATMENT OR MEDICINES RECEIVED (Such as surgery, chemotherapy, radiation, and the medicines including strength and dosage taken for your illness or injury. If no treatment or medicines, indicate "NONE".)		

8. HAVE YOU BEEN TREATED AT ANY OTHER HOSPITALS OR CLINICS FOR YOUR IMPAIRMENTS?  YES  NO (If Yes, complete DSS-1151.1 - Continuation Sheet.)

9. HAVE YOU HAD ANY OF THE FOLLOWING TESTS IN THE LAST YEAR?

TEST	CHECK APPROPRIATE BLOCK OR BLOCKS	IF "YES" SHOW	
		WHERE DONE	WHEN DONE
Electrocardiogram	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Chest X-Ray	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Other X-Ray (Name body part here)	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Breathing Tests	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Blood Tests	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Other (Specify)	<input type="checkbox"/> YES <input type="checkbox"/> NO		

10. HAVE YOU BEEN SEEN BY OTHER AGENCIES FOR YOUR DISABLING IMPAIRMENTS? (VA, Worker's Compensation, Vocational Rehabilitation, etc.)  YES  NO

NAME OF AGENCY	ADDRESS	
YOUR CLAIM NUMBER		
DATES OF VISITS		
CONTACT PERSON	POSITION	

# DISABILITY INTERVIEW

## CONTINUATION SHEET # \_\_\_\_\_

AGENCY

NEW YORK STATE

DEPARTMENT OF SOCIAL SERVICES

NAME OF CLIENT	SOCIAL SECURITY NUMBER	CASE NUMBER
----------------	------------------------	-------------

**A. OTHER DOCTORS SEEN SINCE YOUR IMPAIRMENTS BEGAN:**

1. NAME	ADDRESS	
TELEPHONE NUMBER (include area code) (    )		
HOW OFTEN DO YOU SEE THIS DOCTOR?	DATE YOU FIRST SAW THIS DOCTOR.	DATE YOU LAST SAW THIS DOCTOR.

REASONS AND TREATMENT

2. NAME	ADDRESS	
TELEPHONE NUMBER (include area code) (    )		
HOW OFTEN DO YOU SEE THIS DOCTOR?	DATE YOU FIRST SAW THIS DOCTOR.	DATE YOU LAST SAW THIS DOCTOR.

REASONS AND TREATMENT

**B. OTHER HOSPITALIZATION OR TREATMENT AT A CLINIC FOR YOUR IMPAIRMENTS:**

NAME OF HOSPITAL OR CLINIC	ADDRESS
PATIENT OR CLINIC NUMBER	
CONTACT PERSON	POSITION

WERE YOU AN INPATIENT? (Stayed at least overnight?)     Yes     No    (If Yes, indicate admission and discharge dates.)WERE YOU AN OUTPATIENT?     Yes     No    (If Yes, indicate dates of visits.)

REASON FOR HOSPITALIZATION OR CLINIC VISITS (State illness or injury for which you had an examination or treatment.)

TYPE OF TREATMENT OR MEDICINES RECEIVED (Such as surgery, chemotherapy, radiation, and the medicines including strength and dosage taken for your illness or injury. If no treatment or medicines, indicate "NONE".)

**C. OTHER WORK YOU DID IN THE PAST 15 YEARS:**

1.	JOB TITLE	TYPE OF BUSINESS	DATES WORKED (Month & Year)		HOURS PER WEEK	RATE OF PAY (Per hour, day, week, month or year)	REASON FOR LEAVING
			FROM	TO			

DESCRIBE YOUR BASIC DUTIES:

**DESCRIBE THE KIND AND AMOUNT OF PHYSICAL ACTIVITY THIS JOB INVOLVED DURING TYPICAL DAY IN TERMS OF:**

- WALKING (Circle the number of hours a day spent walking) -- 0 1 2 3 4 5 6 7 8
- STANDING (Circle the number of hours a day spent standing) -- 0 1 2 3 4 5 6 7 8
- SITTING (Circle the number of hours a day spent sitting) -- 0 1 2 3 4 5 6 7 8
- BENDING (Circle how often a day you had to bend) -- Never Occasionally Frequently Constantly
- REACHING (Circle how often a day you had to reach) -- Never Occasionally Frequently Constantly
- LIFTING (Circle heaviest weight lifted) -- Less than 10 lbs., 10 lbs., 20 lbs., 50 lbs., 100 lbs. or more  
(Circle weight frequently lifted) -- Less than 10 lbs., 10 lbs., 25 lbs., 50 lbs. or more

2.	JOB TITLE	TYPE OF BUSINESS	DATES WORKED (Month & Year)		HOURS PER WEEK	RATE OF PAY (Per hour, day, week, month or year)	REASON FOR LEAVING
			FROM	TO			

DESCRIBE YOUR BASIC DUTIES:

**DESCRIBE THE KIND AND AMOUNT OF PHYSICAL ACTIVITY THIS JOB INVOLVED DURING TYPICAL DAY IN TERMS OF:**

- WALKING (Circle the number of hours a day spent walking) -- 0 1 2 3 4 5 6 7 8
- STANDING (Circle the number of hours a day spent standing) -- 0 1 2 3 4 5 6 7 8
- SITTING (Circle the number of hours a day spent sitting) -- 0 1 2 3 4 5 6 7 8
- BENDING (Circle how often a day you had to bend) -- Never -- Occasionally -- Frequently -- Constantly
- REACHING (Circle how often a day you had to reach) -- Never -- Occasionally -- Frequently -- Constantly
- LIFTING (Circle heaviest weight lifted) -- Less than 10 lbs., 10 lbs., 20 lbs., 50 lbs., 100 lbs. or more  
(Circle weight frequently lifted) -- Less than 10 lbs., 10 lbs., 25 lbs., 50 lbs. or more

**PART III -- INFORMATION ABOUT YOUR ACTIVITIES**

11. HAS YOUR DOCTOR TOLD YOU TO CUT BACK OR LIMIT YOUR ACTIVITIES IN ANY WAY?  YES  NO  
 IF "YES" GIVE THE NAME OF THE DOCTOR BELOW AND TELL WHAT HE OR SHE TOLD YOU ABOUT CUTTING BACK OR LIMITING ACTIVITIES.

12. DESCRIBE YOUR DAILY ACTIVITIES IN THE FOLLOWING AREAS AND STATE WHAT AND HOW MUCH YOU DO OF EACH AND HOW OFTEN YOU DO IT:  
 • Household Chores • Recreational activities and hobbies • Social contacts • Other (any similar activities)

**PART IV -- INFORMATION ABOUT YOUR EDUCATION AND LITERACY**

13. SCHOOLING 14. HIGHEST GRADE COMPLETED 15. AGE AT COMPLETION  
 Elementary  H.S.  College  Special Class or School

16. ENGLISH 17. OTHER LANGUAGE(S)  
 Speak  Read  Write  Speak  Read  Write Specify language \_\_\_\_\_

18. PROFESSIONAL OR VOCATIONAL TRAINING (Specify course of study, dates, degrees, certifications etc.)

**PART V -- INFORMATION ABOUT THE WORK YOU DID IN PAST 15 YEARS**

19. HAVE YOU WORKED IN THE PAST 15 YEARS?  YES  NO (If Yes, complete Work History Below.)

JOB TITLE (Most Recent Job)	TYPE OF BUSINESS	DATES WORKED (Month & Year)		HOURS PER WEEK	RATE OF PAY (Per hour, day, week, month or year)	REASON FOR LEAVING
		FROM	TO			

DESCRIBE YOUR BASIC DUTIES:

DESCRIBE THE KIND AND AMOUNT OF PHYSICAL ACTIVITY THIS JOB INVOLVED DURING TYPICAL DAY IN TERMS OF:

- WALKING (Circle the number of hours a day spent walking) -- 0 1 2 3 4 5 6 7 8
- STANDING (Circle the number of hours a day spent standing) -- 0 1 2 3 4 5 6 7 8
- SITTING (Circle the number of hours a day spent sitting) -- 0 1 2 3 4 5 6 7 8
- BENDING (Circle how often a day you had to bend) -- Never Occasionally Frequently Constantly
- REACHING (Circle how often a day you had to reach) -- Never Occasionally Frequently Constantly
- LIFTING (Circle heaviest weight lifted) -- Less than 10 lbs., 10 lbs., 20 lbs., 50 lbs., 100 lbs. or more  
 (Circle weight frequently lifted) -- Less than 10 lbs., 10 lbs., 25 lbs., 50 lbs. or more

JOB TITLE	TYPE OF BUSINESS	DATES WORKED (Month & Year)		HOURS PER WEEK	RATE OF PAY (Per hour, day, week, month or year)	REASON FOR LEAVING
		FROM	TO			

DESCRIBE YOUR BASIC DUTIES:

DESCRIBE THE KIND AND AMOUNT OF PHYSICAL ACTIVITY THIS JOB INVOLVED DURING TYPICAL DAY IN TERMS OF:

- WALKING (Circle the number of hours a day spent walking) -- 0 1 2 3 4 5 6 7 8
- STANDING (Circle the number of hours a day spent standing) -- 0 1 2 3 4 5 6 7 8
- SITTING (Circle the number of hours a day spent sitting) -- 0 1 2 3 4 5 6 7 8
- BENDING (Circle how often a day you had to bend) -- Never Occasionally Frequently Constantly
- REACHING (Circle how often a day you had to reach) -- Never Occasionally Frequently Constantly
- LIFTING (Circle heaviest weight lifted) -- Less than 10 lbs., 10 lbs., 20 lbs., 50 lbs., 100 lbs. or more  
(Circle weight frequently lifted) -- Less than 10 lbs., 10 lbs., 25 lbs., 50 lbs. or more

20. HAVE YOU HAD ANY ADDITIONAL JOBS IN THE PAST 15 YEARS?  YES  NO (If Yes, complete DSS-1151.1 - Continuation Sheet.)

**PART VI -- INTERVIEWER'S OBSERVATIONS**

List Signs and Limitations Observed by Interviewer and any Other Remarks.

SIGNATURE OF WORKER

X

DATE

**PART VII -- SUPERVISORY COMMENTS (Optional)**

SIGNATURE OF SUPERVISOR

X

TITLE

DATE

## MENTAL RESIDUAL FUNCTIONAL CAPACITY ASSESSMENT

NAME	SOCIAL SECURITY NUMBER	CASE NUMBER
CATEGORIES (From IB of the PRTF)	AGENCY'S NAME	APPLICATION DATE
	SIGNATURE OF REVIEWING SOCIAL WORKER	DATE OF THIS REVIEW

### SUMMARY CONCLUSIONS

If an individual has a mental impairment and this impairment does not meet or equal the mental disorders criteria in the Listing of Impairments, the Disability Review Team **MUST** make an assessment of the individual's mental residual functional capacity. This form provides a check list to identify specific areas of mental limitation. Once these areas are identified, the Review Team must evaluate whether or not these limitations prevent the individual from performing his/her past relevant work and/or any other work in the national economy.

The evaluation of these limitations and the extent they prevent the individual from performing his/her past relevant work and/or any other work should be detailed on the casenote and the "Disability Review Team Certificate," DSS-639.

**Note:** A case should not be denied where the reviewer indicates that there is insufficient evidence to evaluate any of the specific areas of mental limitation. These documentation deficiencies should also be included on the casenote and the "Disability Review Team Certificate," DSS-639.

	Not Significantly Limited	Moderately Limited	Markedly Limited	No Evidence of Limitation in this Category	Insufficient Evidence
<b>A. UNDERSTANDING AND MEMORY</b>					
1. The ability to remember locations and work-like procedures.	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
2. The ability to understand and remember very short and simple instructions.	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
3. The ability to understand and remember detailed instructions.	1. <input checked="" type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
<b>B. SUSTAINED CONCENTRATION AND PERSISTENCE</b>					
4. The ability to carry out very short and simple instructions.	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
5. The ability to carry out detailed instructions.	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
6. The ability to maintain attention and concentration for extended periods.	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
7. The ability to perform activities within a schedule, maintain regular attendance, and be punctual within customary tolerances.	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>

**SUSTAINED CONCENTRATION AND PERSISTENCE (Cont'd)**

	Not Significantly Limited	Moderately Limited	Markedly Limited	No Evidence of Limitation in this Category	Insufficient Evidence
8. The ability to sustain an ordinary routine without special supervision.	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
9. The ability to work in coordination with or proximity to others without being distracted by them.	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
10. The ability to make simple work-related decisions.	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
11. The ability to complete a normal work-day and workweek without interruptions from psychologically based symptoms and to perform at a consistent pace without an unreasonable number and length of rest periods.	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>

**C. SOCIAL INTERACTION**

12. The ability to interact appropriately with the general public.	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
13. The ability to ask simple questions or request assistance.	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
14. The ability to accept instructions and respond appropriately to criticism from supervisors.	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
15. The ability to get along with coworkers or peers without distracting them or exhibiting behavioral extremes.	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
16. The ability to maintain socially appropriate behavior and to adhere to basic standards of neatness and cleanliness.	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>

**D. ADAPTATION**

17. The ability to respond appropriately to changes in the work setting.	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
18. The ability to be aware of normal hazards and take appropriate precautions.	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
19. The ability to travel in unfamiliar places or use public transportation.	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
20. The ability to set realistic goals or make plans independently of others.	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>

## PSYCHIATRIC REVIEW TECHNIQUE

NAME	SOCIAL SECURITY NUMBER	CASE NUMBER
AGENCY'S NAME	DATE OF THIS REVIEW	APPLICATION DATE
SIGNATURE OF REVIEWING PHYSICIAN  X	SIGNATURE OF CASE REVIEWER  X	

### I. MEDICAL SUMMARY

**A. Medical Disposition(s):**

- No Medically Determinable Impairment
- Meets Listing \_\_\_\_\_ (Cite Listing and subsection)
- Equals Listing \_\_\_\_\_ (Cite Listing and subsection)
- Impairment is Not Expected to Last 12 Months
- RFC Assessment Necessary (i.e., an impairment is present which does not meet or equal a listed impairment)
- Referral to Another Medical Specialty (necessary when there is a coexisting nonmental impairment)
- Insufficient Medical Evidence

**B. Category(ies) Upon Which the Medical Disposition(s) is Based:**

- 12.02 Organic Mental Disorders
- 12.03 Schizophrenic, Paranoid and other Psychotic Disorders
- 12.04 Affective Disorders
- 12.05 Mental Retardation
- 12.06 Anxiety Related Disorders
- 12.07 Somatoform Disorders
- 12.08 Personality Disorders
- 12.09 Substance Addiction Disorders
- 12.10 Autism and other Pervasive Developmental Disorders

**II. DOCUMENTATION OF FACTORS THAT EVIDENCE THE DISORDER (COMMENT ON EACH BROAD CATEGORY OF DISORDER.)**

**A. 12.02 Organic Mental Disorders**

- No evidence of a sign or symptom CLUSTER or SYNDROME which appropriately fits with this diagnostic category. (Some features appearing below may be present in the case but they are presumed to belong in another disorder and are rated in that category.)
- Psychological or behavioral abnormalities associated with a dysfunction of the brain...as evidenced by at least one of the following:

**PRESENT-ABSENT-INSUFFICIENT EVIDENCE**

1.    Disorientation to time and place
2.    Memory impairment
3.    Perceptual or thinking disturbances
4.    Change in personality
5.    Disturbance in mood
6.    Emotional lability and impairment in impulse control
7.    Loss of measured intellectual ability of at least 15 I.Q. points from premorbid levels or overall impairment index clearly within the severely impaired range on neuropsychological testing, e.g., the Luria-Nebraska, Halstead-Reitan, etc.
8.    Other \_\_\_\_\_

**B. 12.03 Schizophrenic, Paranoid and other Psychotic Disorders**

- No evidence of a sign or symptom CLUSTER or SYNDROME which appropriately fits with this diagnostic category. (Some features appearing below may be present in the case but they are presumed to belong in another disorder and are rated in the category.)
- Psychotic features and deterioration that are persistent (continuous or intermittent), as evidenced by at least one of this following:

**PRESENT-ABSENT-INSUFFICIENT EVIDENCE**

1.    Delusions or hallucinations
2.    Catatonic or other grossly disorganized behavior
3.    Incoherence, loosening of associations, illogical thinking, or poverty of content of speech if associated with one of the following:
  - a.  Blunt affect, or
  - b.  Flat affect, or
  - c.  Inappropriate affect
4.    Emotional withdrawal and/or isolation
5.    Other \_\_\_\_\_

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**C. 12.04 Affective Disorders**

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- No evidence of a sign or symptom CLUSTER or SYNDROME which appropriately fits with this diagnostic category. (Some features appearing below may be present in the case but they are presumed to belong in another disorder and are rated in that category.)
- Disturbance of mood, accompanied by a full or partial manic or depressive syndrome, as evidenced by a least one of the following:

**PRESENT-ABSENT-INSUFFICIENT EVIDENCE**

- 1.    Depressive syndrome characterized by at least four of the following:
    - a.  Anhedonia or pervasive loss of interest in almost all activities, or
    - b.  Appetite disturbance with change in weight, or
    - c.  Sleep disturbance, or
    - d.  Psychomotor agitation or retardation, or
    - e.  Decreased energy, or
    - f.  Feelings of guilt or worthlessness, or
    - g.  Difficulty concentrating or thinking, or
    - h.  Thoughts of suicide, or
    - i.  Hallucinations, delusions or paranoid thinking
  - 2.    Manic syndrome characterized by at least three of the following.
    - a.  Hyperactivity, or
    - b.  Pressures of speech, or
    - c.  Flight of ideas, or
    - d.  Inflated self-esteem, or
    - e.  Decreased need for sleep, or
    - f.  Easy distractibility, or
    - g.  Involvement in activities that have a high probability of painful consequences which are not recognized, or
    - h.  Hallucinations, delusions or paranoid thinking
  - 3.    Bipolar syndrome with a history of episodic periods manifested by the full symptomatic picture of both manic and depressive syndromes (and currently characterized by either or both syndromes)
  - 4.    Other \_\_\_\_\_
-

**D. 12.05 Mental Retardation**

- No evidence of a sign or symptom CLUSTER or SYNDROME which appropriately fits with this diagnostic category. (Some features appearing below may be present in the case but they are presumed to belong in another disorder and are rated in that category.)
- Significantly subaverage general intellectual functioning with deficits in adaptive functioning initially manifested during the developmental period (before age 22) as evidenced by at least one of the following:

**PRESENT-ABSENT-INSUFFICIENT EVIDENCE**

1.    Mental incapacity evidenced by dependence upon others for personal needs (e.g., toileting, eating, dressing or bathing) and inability to follow directions, such that the use of standardized measures of intellectual functioning is precluded.
2.    A valid verbal, performance, or full scale I.Q. of 59 or less.
3.    A valid verbal, performance, or full scale I.Q. of 60 through 70 inclusive and a physical or other mental impairment imposing an additional and significant work-related limitation of function.
4.    A valid verbal, performance, or full scale I.Q. of 60 through 70 resulting in a least two of the "B" criteria on Page 7.
5.    Other \_\_\_\_\_

**E. 12.06 Anxiety Related Disorders**

- No evidence of a sign or symptom CLUSTER or SYNDROME which appropriately fits with this diagnostic category. (Some features appearing below may be present in the case but they are presumed to belong in another disorder and are rated in that category.)
- Anxiety as the predominant disturbance or anxiety experienced in the attempt to master symptoms, as evidenced by at least one of the following:

**PRESENT-ABSENT-INSUFFICIENT EVIDENCE**

1.    Generalized persistent anxiety accompanied by three of the following:
  - a.  Motor tension, or
  - b.  Autonomic Hyperactivity, or
  - c.  Apprehensive expectation, or
  - d.  Vigilance and scanning
2.    A persistent irrational fear of a specific object, activity or situation which results in a compelling desire to avoid the dreaded object, activity, or situation.
3.    Recurrent severe panic attacks manifested by a sudden unpredictable onset of intense apprehension, fear, terror, and sense of impending doom occurring on the average of at least once a week.
4.    Recurrent obsessions or compulsions which are a source of marked distress.
5.    Recurrent and intrusive recollections of a traumatic experience, which are a source of marked distress.
6.    Other \_\_\_\_\_

**F. 12.07 Somatoform Disorders**

- No evidence of a sign or symptom CLUSTER or SYNDROME which appropriately fits with this diagnostic category. (Some features appearing below may be present in the case but they are presumed to belong to another disorder and are rated in that category.)
- Physical symptoms for which there are no demonstrable organic findings or known physiological mechanisms, as evidenced by at least one of the following:

**PRESENT-ABSENT-INSUFFICIENT EVIDENCE**

1.    A history of multiple physical symptoms of several years duration beginning before age 30, that have caused the individual to take medicine frequently, see a physician often and alter life patterns significantly
2.    Persistent nonorganic disturbance of one of the following:
- a.  Vision, or
  - b.  Speech, or
  - c.  Hearing, or
  - d.  Use of a limb, or
  - e.  Movement and its control (e.g., coordination disturbances, psychogenic seizures, akinesia, dyskinesia), or
  - f.  Sensation (e.g., diminished or heightened)
3.    Unrealistic interpretation of physical signs or sensations associated with the preoccupation or belief that one has a serious disease or injury.
4.    Other \_\_\_\_\_

**G. 12.08 Personality Disorders**

- No evidence of a sign or symptom CLUSTER or SYNDROME which appropriately fits with this diagnostic category. (Some features appearing below may be present in the case but they are presumed to belong in another disorder and are rated in that category.)
- Inflexible and maladaptive personality traits which cause either significant impairment in social or occupational functioning or subjective distress, as evidenced by at least one of the following:

**PRESENT-ABSENT-INSUFFICIENT EVIDENCE**

1.    Seclusiveness or autistic thinking.
2.    Pathologically inappropriate suspiciousness or hostility.
3.    Oddities of thought, perception, speech and behavior.
4.    Persistent disturbances of mood or affect.
5.    Pathological dependence, passivity, or aggressivity.
6.    Intense and unstable interpersonal relationships and impulsive and damaging behavior.
7.    Other \_\_\_\_\_

**H. 12.09 Substance Addiction Disorders**

Behavioral changes or physical changes associated with the regular use of substances that affect the central nervous system.

Present       Absent       Insufficient Evidence

If present, evaluate under one or more of the most closely applicable listings:

1.  Listing 12.02 – Organic mental disorders\*
2.  Listing 12.04 – Affective disorders\*
3.  Listing 12.06 – Anxiety disorders\*
4.  Listing 12.08 – Personality disorders\*
5.  Listing 11.14 – Peripheral neuropathies\*
6.  Listing 5.05 – Liver Damage\*
7.  Listing 5.04 – Gastritis\*
8.  Listing 5.08 – Pancreatitis\*
9.  Listing 11.02 or 11.03 – Seizures\*
10.  Other \_\_\_\_\_

\*NOTE: Items 1, 2, 3, 4, 5, 6, 7, 8 and 9 correspond to Listings 12.09A, 12.09B, 12.09C, 12.09D, 12.09E, 12.09F, 12.09G, 12.09H, and 12.09I, respectively. If items 1, 2, 3, or 4 are checked, only the numbered items in subsection 11A, 11C, 11E, or 11G of the form need be checked. The first two blocks under the disorder heading in those subsections need not be checked.

**I. 12.10 Autistic Disorder and Other Pervasive Developmental Disorders**

- No evidence of a sign or symptom CLUSTER or SYNDROME which appropriately fits with this diagnostic category. (Some features appearing below may be present in the case but they are presumed to belong in another disorder and are rated in that category.)
- Qualitative deficits in the development of reciprocal social interaction, in the development of verbal and nonverbal communication skills, and in imaginative activity. Often there is a markedly restricted repertoire of activities and interests, which frequently are stereotyped and repetitive.

**PRESENT-ABSENT-INSUFFICIENT EVIDENCE**

1.    Autistic disorder, with medically documented findings of all of the following:
  - a.  Qualitative deficits in reciprocal social interaction.
  - b.  Qualitative deficits in verbal and nonverbal communication and in imaginative activity.
  - c.  Markedly restricted repertoire of activities and interests.
2.    Other pervasive developmental disorders, with medically documented findings of both of the following:
  - a.  Qualitative deficits in reciprocal social interaction.
  - b.  Qualitative deficits in verbal and nonverbal communication and in imaginative activity.

**III. RATING OF IMPAIRMENT SEVERITY**

**A. "B" Criteria of the Listings**

Indicate to what degree the following functional limitations (which are found in paragraph B of listings 12.02-12.04 and 12.06-12.08 and 12.10 and paragraph D of 12.05) exist as a result of the individual's mental disorder(s).

NOTE: To satisfy the Listings, there must be at least 2 functional limitations at a marked or greater level (in the case of Item 4, three episodes or more are required to satisfy the Listings).

Specify the Listing(s) (i.e., 12.02 through 12.09) under which the items below are being rated \_\_\_\_\_

FUNCTIONAL LIMITATION	DEGREE OF LIMITATION					
Restriction of Activities of Daily Living	None <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Marked* <input type="checkbox"/>	Extreme* <input type="checkbox"/>	Insufficient Evidence <input type="checkbox"/>
2. Difficulties in Maintaining Social Functioning	None <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Marked* <input type="checkbox"/>	Extreme* <input type="checkbox"/>	Insufficient Evidence <input type="checkbox"/>
3. Difficulties in Maintaining Concentration, Persistence or Pace	None <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Marked* <input type="checkbox"/>	Extreme* <input type="checkbox"/>	Insufficient Evidence <input type="checkbox"/>
4. Repeated Episodes of Decompensation, each of Extended Duration**	None <input type="checkbox"/>	One or Two <input type="checkbox"/>		Three* <input type="checkbox"/>	Four* or more <input type="checkbox"/>	Insufficient Evidence <input type="checkbox"/>

Degree of limitation that satisfies the functional criterion.

The term repeated episodes of decompensation, each of extended duration, means three episodes within 1 year or an average of one episode every 4 months, each lasting for at least 2 weeks. If episodes are more frequent and of shorter duration or less frequent and of longer duration, determine if the duration and functional effects of the episodes are of equal severity and may be used to substitute for the listed finding in a determination of equivalence.

**B. "C" Criteria of the Listings**

Complete this section if 12.02 (Organic Mental), 12.03 (Schizophrenic, etc.) 12.04 (Affective) or 12.06 (Anxiety) applies and the requirements in paragraph B of the appropriate listing are not satisfied.

- 1 Medically documented history of a chronic organic mental (12.02), schizophrenic, etc. (12.03) or affective (12.04) disorder of at least 2 years duration that has caused more than a minimal limitation of ability to do any basic work activity, with symptoms or signs currently attenuated by medication or psychosocial support, and one of the following:

	Present	Absent	Insufficient Evidence	
a.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Repeated episodes of decompensation, each of extended duration.
b.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	A residual disease process that has resulted in such marginal adjustment that even a minimal increase in mental demands or change in the environment would be predicted to cause the individual to decompensate.
c.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Current history of 1 or more years of inability to function outside a highly supportive living arrangement with an indication of continued need for such an arrangement.

2. Medically documented history of an Anxiety Related (12.06) disorder with the following:

	Present	Absent	Insufficient Evidence	
a	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Symptoms resulting in <i>complete</i> inability to function independently outside the area of one's home.

Transitioning the  
Medicaid Buy-In program for  
Working People with Disabilities  
(MBI-WPD)  
And  
The Disability Determinations  
Process

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MBI-WPD Topics

- Outline the plan for transition of the MBI program
- Key dates for implementation of the plan
- Systems items and notices for the MBI program
- Review the basics requirements for MBI
- Update from Albany Central Office

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MBI Program Statistics

- 1,500 Applications
- 1,030 Approved
- 45 Denied
- 19 Withdrawn

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## Key Dates

- June 30, 2004 Farewell to Inter-Agency Team
- July 1, 2004 LDSS staff assume responsibility for all MBI cases
  - New
  - Spenddown Conversions
- LDSS is already responsible for
  - Undercare
  - Recertifications

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## Important Transition Dates

- June 30, 2004 Last day to send MBI applications to the Albany Central Office (ACO)
- Pending cases in Albany prior to July 1, 2004 processed in by ACO staff
- State Disability Review Team continues to perform disability determinations for all MBI cases, including Continuing Disability Reviews

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## MBI Five Basic Criteria

1. Age: 16 – 64 years
2. Disability Certification:
  - Accept: SSA award letter
  - No Existing Certification?: State Disability Review Team for determination needed
3. Work
4. Income Standard 250% Federal Poverty Level
5. Resources Standard \$10,000

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## MBI Basic Group

- At least 16 but not yet 65 years of age
- Meet SSI definition of disability
- Engaged in work activity for which financial compensation is received and all applicable taxes are paid
- Meet the income and resource tests

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## Medical Improvement Group

- Participant in the Basic Group but lost eligibility for that group due to medical improvement and retains a severe medical impairment
- At least 16 but not yet 65 years of age
- Working at least 40 hours per month earning at least the federal minimum wage
- Meet the income and resource tests

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## Caution!

No recipient may participate in the Medical Improvement Group unless determined eligible for this group by the State Disability Review Team in Albany

### Individual Category Code

- 70 = Basic Group
- 71 = Medical Improvement Group

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### Situation # 1

A new applicant for the MBI-WPD program is 25 years old, certified disabled by SSA, working 40 hours a month and meets the income and resource tests. Is the applicant eligible for the Medical Improvement Group?

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### Solution to Situation #1

No

An applicant must be a participant in the Basic Group before becoming eligible for the Medical Improvement Group and must have lost eligibility in the Basic Group due to improvement in his/her medical condition. This applicant may be eligible for the Basic Group (Indiv. Cat Code = 70)

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### Tips and Reminders

#### Work Requirement

Current pay stubs are needed before authorizing or recertifying a case!

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## Tips and Reminders

Be sure to double-check the applicant's **age!**

Remember  
The age range is

16-64

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## Tips and Reminders

Disability Certification from the Social Security Administration or State/Local Disability Review Team is needed.

If no disability certification exists, send medical evidence to the State Disability Review Team in Albany!

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## Tips and Reminders

### **Reducing Countable Income/Resources**

#### **Income**

Impairment Related Work Expenses (IRWE)  
Plan for Achieving Self-Support (PASS)

#### **Resources**

Plan for Achieving Self-Support (PASS)

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## Tips and Reminders

PASS forms may be accessed online at  
[www.passonline.org](http://www.passonline.org)

- Assistance with completing a PASS application may be obtained at:
  - Local Social Security Administration office
  - Benefits Planning, Assistance and Outreach

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## Tips and Reminders

- Outreach, Education and Client Assistance contractors are available to help Applicants/Recipients
- VESID is available for referral

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## True/False Question

TRUE OR FALSE

Once the transition occurs, a county that normally performs their own disability determinations will start doing disability determinations for the MBI-WPD program.

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## Answer to True/False Question

**FALSE**

Even after the transition new disability determinations and Continuing Disability Reviews (CDR) for **ALL** MBI-WPD applications are always performed by the State Disability Review Team in Albany

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## Recertification

- **Age:** Still between 16 and 64 years old?
- **Work:** Check for current pay stub
- **Disability:** Does the Recipient have current disability status? Are they due for a continuing disability review? Remember to send the medical evidence to the State Team in Albany for review!
- **Income and Resources:** Remember IRWEs and PASS!

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## Recertification

- If the Recipient continues to be eligible for MBI, put them up for 12 months
- If ineligible for MBI, remember to consider transferring them to spenddown as opposed to closing the case.

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## Multiple Choice Question

A MBI Recipient applies for recertification in June. In checking the disability documentation you notice that the disability approval expires in August. The individual continues to be otherwise eligible for MBI. You decide to:

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## Multiple Choice

- A) Automatically extend the disability certificate because everyone knows disabilities never get better.
- B) Prepare the disability review for your local Disability Review Team.
- C) Prepare and send the disability review package for determination by the State Disability Review Team in Albany.
- D) Take a Flintstone Vitamin and a 16 oz. glass of water.
- E) None of the above.

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Answer: Both C and D

Both C and D!

Prepare and send the disability review package for determination by the State Disability Review Team because even after the July transition the State Disability Review Team will perform disability determinations for all working individuals with disabilities

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## Grace Periods

A grace period is a time period during which a MBI-WPD program participant is not working but remains eligible for the program

Recipients may be granted multiple grace periods, however, the sum of the grace periods can not exceed 6 months in a 12-month period

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## Grace Periods: Two Types

1. Change in Medical Condition: Medical verification is required
2. Job loss through no fault of the Recipient: Verify that the recipient's intent to return to employment

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## Process for Grace Periods

- Recipient completes grace period request form and submits it along with supporting documentation to LDSS
- LDSS staff reviews and approves request if possible
- Signed decision is sent to Recipient
- Letter sent with the decision tells Recipient steps to take when grace period draws to a close

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## Tracking Grace Periods

emt04@health.state.ny.us

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## Grace Period Situation

In August, Bob M., a Recipient approved for the MBI Basic Group from Jan. 1, 2004 through Dec. 31, 2004, notifies you that he suffered an exacerbation of his disabling impairment and has completed a grace period request form asking for two months "grace" on MBI. You check the database (or file) and note that he has already had two grace periods approved; one for 30 days that started on March 2, 2004 and another for 60 days in May - June 2004. Is Bob eligible for another grace period as requested? How would you proceed?

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## Answer to G P Situation

**Bob is eligible!**

Bob is eligible for the requested grace period. A total of 6 months is allowed in a 12 month period and at the time of this request he has only used a total of 3 months. Note that the tracking period in Bob's case began March 2, 2004 and would end in February 2005.

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### Answer to G P Situation How to proceed

- Complete and sign the grace period request form and mail it to the Recipient
- Keep a copy for your files
- Notation on the database or in the tickler file so you can follow up at the appropriate time
- Send the Recipient a copy of the letter for Recipients granted a grace period

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### Expanded Eligibility Codes (EEC)

- 'V' ~ MBI-WPD (SSI –Related budgeting prior to MBI-WPD)
- 'W' ~ MBI-WPD (Only)
- Valid with:
  - Budget Type (BT) must be 04,05 or 06

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### MBL Input Field for PASS

- PASS –
  - Plan for Achieving Self-Support Amount is entered in the field
- Valid with EEC of 'V' or 'W'

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## Second EEC Screen

Display:

MBI-WPD Total Net Income  
And  
One of the following messages:

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## Second EEC Screen Display

Eligible	150%	Amt
<u>Or</u> Eligible	250%	Amt
<u>Or</u> Ineligible Income	250%	Amt
<u>Or</u> Ineligible Resources		10,000
<u>Or</u> Ineligible Inc/Res	250%	10,000

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## Individual Categorical Codes for MBI

- 70 – MBI Basic Group
- 71 – MBI Medical Improvement Group

Valid with:

Medicaid Coverage Codes 01, 10 or 30  
Individual between 16 and 64 years of age

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### MBI Recipient Aid Category Codes

- 82 – MBI Basic Group
- 83 – MBI Medical Improvement Group

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### MBI Restriction/Exemption Codes

- 90 – Managed Care Excluded
  - Net income between 150% and 250% FPL
- 91 – Managed Care Exempt
  - Net income below 150% who do not choose to be in Managed Care

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### Client Notification System Notices

- CNS notices available for denial, discontinuance and undercare
- Manual Notice for Acceptance
- Two notices for migration in July:
  - MBI-WPD to Spenddown, SD not met
  - MBI-WPD to Spenddown non-financial reasons, SD not met

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## Disability Determinations Topics

- Fresh look at disability determinations
- Putting together a complete disability package
- Current disability determinations issues and concerns
- Steps to maximize the efficiency of forms
- Interviewing tips

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## Disability Determinations

- Disability Manual
- DSS-1151 Disability Interview Tool
- DSS-486T Medical Report For Determination of Disability
- Case Documentation (supporting medical evidence)
- Writing a DSS-639 that adequately supports the case decision

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## Reasons to Perform Disability Reviews

- Applicant/Recipient claims to have a severe impairment that has lasted or is expected to last at least 12 months
- When requested by OMM audit staff reviewing high cost cases

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## Disability Manual

- Definitions
- Local District responsibilities
- Disability policy
- Listings of Impairments

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## Forms

- DSS-1151
- DSS-486T
- Supporting Medical Evidence

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## DSS-1151

- **Interview Tool:** Structures the interview
  - Captures information
    - Application date
    - SSI/SSDI history
    - Medical provider contacts
    - Educational history
    - Work history
  - Elicits history vital to disability determination
  - Makes case development easier

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## Interview Tips

- Make the client as comfortable as possible
- Provide a non-threatening environment
- Be conversational but goal directed
- Be clear that the intent and expected outcome is to gather a complete social and medical history
- Don't rush! Allow the client adequate time to answer each question

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## DSS-486T

- Extremely valuable form(s) for disability determination
- Divided by body system
- Entire form may be used or, for medical specialty, only the appropriate section(s) may be sent to the provider(s)
- Must be completed and signed by a physician

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## Supporting Medical Evidence

- Possible Sources include any source of medical documentation.

For example:

- Hospitals
- Clinics
- Ancillary Health Care Providers

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## Forms, Forms, Forms!

- DSS-3818 Psychiatric Review Technique
- DSS-3817 Mental Residual Functional Capacity Assessment
- Childhood Disability Evaluation Form

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## Psychiatric Review Technique Form DSS-3818

- Follows the listings for mental impairments
- Mapped out by symptomatology
- Useful to disability reviewer in deciding whether impairment meets a listing

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## Mental Residual Functional Capacity Assessment Form

DSS-3817

- Valuable for making determinations in cases that do not readily meet a listing
- Used by the disability reviewer to determine an individual's level of function if medical evidence does not meet a listing
- Signals areas of function that are "Markedly limited"

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## Childhood Disability Eval. Form

- Used to adjudicate children's impairments
- Useful to disability reviewer to determine a child's functional equivalence if a case does not meet a listing
- Used to determine if there are marked limitations in two domains or an extreme limitation in one domain

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## Acceptable Sources of Medical Documentation

- Licensed: Physicians, Osteopaths, Optometrists, Podiatrists
- Psychologists, including school
- State Certified Speech-Language Pathologists
- Persons authorized by a hospital, clinic or health care facility to provide a copy or summary of medical records

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## Additional Sources of Information

- Other Practitioners: Physician Assistants, Nurse Practitioners, Naturopaths
- Educational personnel: Teachers, Guidance Counselors, Early Intervention Team members, Day Care Workers
- Public and private social welfare agencies

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## Sequential Evaluation Process

- Five step process
- Used by SSA in determining SSI and SSDI eligibility
- Same process used by Medicaid for disability determinations

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## DSS-639 Core Elements

- State the decision
- Cite listing or regulation
- Client's gender, age, education
- Client's work history
- Brief medical history
- Supporting medical evidence and
- How evidence supports the decision

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## Approval

- 1<sup>st</sup> Paragraph: This case is approved because...
- 2<sup>nd</sup> Paragraph: Client is a 49 year old male with...(case history)
- 3<sup>rd</sup> Paragraph: Objective findings (Why client meets>equals/ med.voc.)

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## Disapproval

- 1<sup>st</sup> Paragraph: This case is disapproved because...
- 2<sup>nd</sup> Paragraph: Client is a 49 year old...
- 3<sup>rd</sup> Paragraph: Objective findings (Why client doesn't meet, equal, med. voc. Disapproval)
- 4<sup>th</sup> Paragraph: If condition changes, resubmit with new ME

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## No Action

- 1<sup>st</sup> Paragraph: This case is returned as a No Action because there is insufficient medical evidence
- 2<sup>nd</sup> Paragraph: State specifically what is needed

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## Psychiatric Listings

- 'A' Criteria address symptoms of the impairment(s)  
**"A" cannot stand alone!**
- 'B' Criteria addresses the impairment related functional limitations
- 'C' Criteria is used for 12.02, 12.03, 12.04, 12.06 only after the 'B' criteria is not satisfied

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## Consultative Exam

- Gather all existing documentation
- Arrange Consultative Exam if no/insufficient documentation exists
- Regulatory authority 18 NYCRR 360-5.5
- Agency pays for exam, claim as administrative expense for FFP

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## MBI-WPD Disability Determinations

MBI-WPD Disability Determinations will continue to be performed by the State Disability Review Team in Albany

### **HOWEVER**

Providers will no longer be instructed to send medical evidence directly to the Albany office.

Local district staff will gather the disability evidence and send it to the Albany office once the package is complete.

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## Recap

- Beginning July 1, 2004 LDSS gather medical documentation for MBI disability review and send the complete package to the State Disability Review Team in Albany
- **All** new MBI and **all** continuing disability reviews (CDRs) for the MBI-WPD program are to be performed by the State Disability Review Team

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