MEDICAID DISABILITY APPLICATION INSTRUCTIONS

THIS FORM MUST BE SUBMITTED TO YOUR COUNTY MEDICAID OFFICE

IF YOU NEED HELP

If you need help with this form, do as much of it as you can, and then **your county technician will help you finish it.**

HOW TO COMPLETE THIS FORM

The information that you give on this form will be used to decide if you meet the disability criteria for Medicaid benefits in Colorado. **Please remember that being found disabled does not guarantee you will receive Medicaid.** You must meet all of the eligibility criteria, which includes disability. These include: 1) disability 2) financial and 3) level of care to receive Medicaid.

- If you ever applied to the Social Security Administration (SSA) for Disability Benefits, **include copies of all letters and notices from SSA**.
- **Do not leave answers blank.** If you do not know the answer, or the answer is “none” or “does not apply,” please write: “don’t know” or “none” or "does not apply.”
- Each address should include a **Zip Code**. Each phone number should include an **Area Code**. You must provide complete information for **each doctor** you identify on this form. Failure to provide complete information may result in those medical records not being used to make a decision on your case.
- **Do not ask a doctor or hospital to complete this form.** But, you may get help from a friend, counselor, case manager, County Medicaid technician, or family member.
- Be sure to show **complete dates** (month/day/year), and explain an answer if the question asks for detail or if you want to give additional information.
- If you need more space or want to tell us more about an answer, please use the “REMARKS” in Section 8 on page 10. Show the number of the question being answered.
- You may send copies of any medical records you have with this application.

MEDICAID DISABILITY APPLICATION	County Date of Application _____

Start Here

Section 1 – Information About The Disabled Person(s)

A. **Name** (First, Middle Initial, Last)	B. **Social Security Number**
C. **Mailing Address** (Street, City, State, and Zip Code)	

D. **Daytime Telephone Number** (If you have no phone where you can be reached, give us a daytime number where we can leave a message for you.)

(_____)_____ This is ○ Your number ○ Message ○ None

E. Give the name of a friend or relative that we can contact (other than your doctor) who knows about your conditions and can help you with your application.

Name_____ Relationship _____

Mailing Address _____
(Number, Street, Apt. No. [if any], P.O. Box, or Rural Route)

_____ (____)_____
City *State* *Zip* Phone

F. What is your height without shoes? _____ _____
Feet *Inches*

G. What is your weight without shoes? _____
Pounds

H. What is your:

_____ _____ _____
Date of Birth Age Sex

I. Can you speak English? ○ Yes ○ No
If "No," what languages can you speak? _____

If you cannot speak English, is there someone we may contact who speaks English and will give you a message? *(If this is the same person as in "E" above, write "Same" here.)*

Name_____ Relationship _____

Mailing Address _____
(Number, Street, Apt. No. [if any], P.O. Box, or Rural Route)

_____ (____)_____
City *State* *Zip* Phone

J. Can you read English? ○ Yes ○ No
K. Can you write more than your name in English? ○ Yes ○ No

Section 2 – Your Conditions and How They Affect You

A. What are your disabling conditions?

_____

_____

B. How do your conditions limit your ability to work?

_____

_____

C. Do your conditions cause you pain or other symptoms? ○ Yes ○ No

D. When did your conditions first bother you?

Month	*Day*	*Year*

E. When did you become unable to work because of your conditions?

Month	*Day*	*Year*

F. Have you ever worked? ○ Yes ○ No *(If "No," go to Section 4.)*

G. Did you work at any time after the date your conditions first bothered you?
○ Yes ○ No

H. If "Yes," did your conditions cause you to: *(check all that apply)*
☐ Work fewer hours? *(explain below)*
☐ Change your job duties? *(explain below)*
☐ Make any job-related changes such as your attendance, help needed, or change of employers? *(explain below)*

_____

_____

_____

I. Are you working now? ○ Yes ○ No

If "No," when did you stop working?

Month	*Day*	*Year*

J. Why did you stop working? _____

K. Have you ever applied for **Social Security Disability Income (SSDI) or Supplemental Security Income (SSI)**? ○ Yes ○ No
If "Yes," on what date did you file the most recent application? _____
Was your Social Security claim: ○ Allowed ○ Denied ○ Still pending
What was the date of your most recent decision?
If you appealed, on what date did you file the appeal?

Please include copies of all letters and notices from SSA

Section 3 – Information About Your Work

A. List the kinds of jobs that you had during the **last 15 years that you worked.**

Job Title *(see example)*	**Type of Business**	**Dates Worked** *(month/year)* From	To	**Hours Per Day**	**Days Per Week**	**Rate of Pay** ***(Per hour, day, week, month, or year)***	
Cook	*Restaurant*	*9/99*	*10/02*	*8*	*5*	*$ 7.00*	*hour*
						$	
						$	
						$	
						$	

B. Which job did you do the longest? _____

C. Describe this job. What did you do all day?
(If you need more space, write in the "Remarks" in Section 8.)

_____

D. In this job, did you:

Use machines, tools, or equipment?	○ Yes	○ No
Use technical knowledge or skills?	○ Yes	○ No
Do any writing, complete reports, or perform duties like this?	○ Yes	○ No

E. In this job, how many <u>total</u> hours each day did you do each of the following:

Walk	_____	Kneel *(bend legs to rest on knees)*	_____
Stand	_____	Crouch *(bend legs and back down and forward)*	_____
Sit	_____	Handle, grab, or grasp big objects	_____
Climb	_____	Crawl *(move on hands and knees)*	_____
Stoop *(bend down and forward at waist)*	_____	Reach overhead	_____
		Handle small objects, write, or type	_____

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

_____

G. Check the heaviest weight lifted:

☐ Less than 10 pounds ☐ 10 pounds ☐ 20 pounds
☐ 50 pounds ☐ 100 pounds or more ☐ Other_____

H. Check the weight frequently lifted:
(Frequently means from 1/3 to 2/3 of the workday.)

☐ Less than 10 pounds ☐ 10 pounds ☐ 20 pounds
☐ 50 pounds ☐ 100 pounds or more ☐ Other_____

I. Did you supervise other people in this job? ○ Yes ○ No
If "No," go to Section 4; If "Yes," complete the following.
How many people did you supervise? _____
What part of your time was spent supervising people? _____ hours
Did you hire and fire employees? ○ Yes ○ No

Section 4 – Information About Your Medical Records

A. Have you been seen by a **doctor/hospital/clinic** or anyone else for the conditions that limit your ability to work? ○ Yes ○ No

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

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

C. List other names you have used on your medical records, including your maiden or married names.

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

D. List each doctor/clinic/therapist/medical professional you have used. Use an extra sheet, if needed. Please include **date last seen and date of your next appointment**.

Name			
Street Address			**Date First Seen**
City	**State**	**Zip**	**Date Last Seen**
Phone ( )			**Next Appointment**
Reason(s) for Visits			
What treatment was received?			

Name			
Street Address			**Date First Seen**
City	**State**	**Zip**	**Date Last Seen**
Phone ( )			**Next Appointment**
Reason(s) for Visits			
What treatment was received?			

Name			
Street Address			**Date First Seen**
City	**State**	**Zip**	**Date Last Seen**
Phone ( )			**Next Appointment**
Reason(s) for Visits			
What treatment was received?			

If you need more space, use "Remarks" in Section 8.

E. List each **hospital** you have used. **Include dates and type of visit.**

Name		
Street Address		
City	**State**	**Zip**
Phone ( )		
Type of Visits		
○ **Inpatient Stays** *(stayed at least overnight)*	Date In	Date Out
○ **Outpatient Visits** *(sent home same day)*	Date of First Visit	Date of Last Visit
○ **Emergency Room Visits**	Date	

Name		
Street Address		
City	**State**	**Zip**
Phone ( )		
Type of Visits		
○ **Inpatient Stays** (stayed at least overnight)	Date In	Date Out
○ **Outpatient Visits** *(sent home same day)*	Date of First Visit	Date of Last Visit
○ **Emergency Room Visits**	Date	

If you need more space, use "Remarks" in Section 8.

Section 5 – Tests

Have you had any medical tests for your conditions? ◯ Yes ◯ No
(If "Yes," complete the information below.)

Kind of Test	When was test done? (month/day/ year)	Where was test done? (Name of facility)	Who sent you for this test?
EKG (heart test)			
Treadmill (exercise test)			
Biopsy – Name of body part			
Hearing Test			
Vision Test			
IQ Test			
EEG (brain wave test)			
HIV Test			
Blood Test (not HIV)			
Breathing Test			
X-Ray – Name of body part _____			
MRI/CT Scan – Name of body part _____			
Other– Name of test and on what body part _____			

If you have had other tests, list them in "Remarks" in Section 8.

Section 6 – Medications

Do you currently take any **medications** for your conditions? ○ Yes ○ No

If "Yes," please tell us the following information:
(Look at your medicine bottles, if necessary.)

Name of Medicine	Name and Phone Number of Doctor	Reason for Medicine	Side effects from the Medicine

Section 7 – Education/Training Information

A. Check the highest grade of school completed.

Grade school:
0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○ 11 ○ 12 ○ GED ○

College:
1 ○ 2 ○ 3 ○ 4 or more ○

Approximate date completed: _____

B. Did you attend special education classes? ○ Yes ○ No
If "Yes," complete the following information:

Name of School _____

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

_____
City *State* *Zip*

Date Attended _____ to _____

Type of Program _____

Section 8 – Remarks

Use this section for any additional information you did not share in an earlier part of this form. When you have completed this section (or if you don't have anything to add), go to the next page and complete the signature block.

Section 8 – Remarks (Continued)

******THIS APPLICATION MUST BE SIGNED******

By signing this application, I affirm that everything is true to the best of my knowledge. I understand that I am giving the Department of Health Care Policy and Financing and its designees the authority to make the necessary contacts to verify any statements made on this application and to request all records/information necessary to determine medical disability eligibility. I understand that this application does not guarantee any benefits will be paid to me or on my behalf.

Signature of **claimant** or person filing on claimant's behalf ***(parent, guardian)***	**Date** *(Month, day, year)*

Witnesses are required **ONLY** if this statement has been signed by an (X) mark above. If signed by an (X) mark, two witnesses to the signing who know the person making the statement must sign below, giving their full addresses.

1. Signature of **Witness**	2. Signature of **Witness**
Address *(number and street, city, state, and zip code)*	**Address** *(number and street, city, state, and zip code)*

County Technician's Comments:

Technician's Printed Name	**Technician's Signature**
County Department	**Date**
Telephone and FAX Numbers	**Technician's Email address**
Supervisor's Name	**Supervisor's Telephone Number**

If you want or need someone to help you with your claim, please complete this form

DESIGNATION OF PERSONAL REPRESENTATIVE

For the Use and Disclosure of Protected Health Information

The Health Insurance Portability and Accountability Act of 1996 states that you have the right to have one or more persons act as your representative to make decisions about the uses and sharing of your protected health information. You can limit the amount of protected health information that the authorized personal representative(s) can decide about, and you can cancel this at any time. See the Department's Privacy Policy and Procedures on *Personal Representatives,* pursuant to 45 C.F.R. 164.502(g).

Date: _____

DESIGNATION OF PERSONAL REPRESENTATIVE

I,_____(print your name) hereby name the following person to act as my authorized personal representative with respect to decisions involving the use and/or sharing of protected health information that pertains to me.

_____ _____

Name of Personal Representative Relationship to Applicant

_____ _____

Personal Representative Social Security # Personal Representative Phone

LIMITS TO THE AMOUNT OF INFORMATION PROVIDED – Please check one

☐ The person named above is to be given all of the privileges that would be given to me with respect to my protected health information.

☐ The person named above is acting as my designated personal representative ONLY for the following function(s):

_____

_____

State ID number:_____Applicant signature: _____

Date of birth:_____Social Security # : _____

REVOCATION SECTION

I understand that I may cancel this designation at any time by signing the revocation section below and returning it to the Department's Privacy Officer at the above address. I understand that any revocation can only apply to future disclosures or actions regarding my protected health information and cannot cancel actions taken or disclosures made while the designation was in effect.

I no longer want this person to act as my personal representative.

Signature: _____ Date: _____

HOW TO COMPLETE MEDICAL RELEASE FROMS

- **Only your signature is needed**. Sign your full name in the space marked "INDIVIDUAL authorizing disclosure."
- Sign each release form.
- Leave all other areas blank. **Do not date** the release forms**.**
- You need to sign **one (1) release for every doctor or hospital** you have listed on this form. You also need to sign **three (3) additional** release forms for any new or discovered medical sources.
- If you do not have enough release forms, please contact your county technician to get more.

REQUEST ENOUGH RELEASE FORMS

Count the number of doctors, hospitals, and medical sources you listed in the application and write that number on this line. **A.** _____

The number of extra release forms you need is 3 **B.** **+ 3**

TOTAL: **A + B = C.** Add the number you listed in A and the number listed in B. That tells you the total number of release forms you need. **C.** _____

If the number of release forms listed in "C" is more than you have in the application packet, call your county worker and ask them to send you more.