

Section I – Identification

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|---|---|--|--|
| Agency State Disability Review Unit OCP-826 State of New York Department of Health Albany, NY 12237 Telephone Number: 1(866) 330-0591 | Patient Name (Last, First, Middle) _____ Address (Street, City, State & Zip Code): _____ _____ _____ | Date of Birth _____ / _____ / _____ Sex <input type="checkbox"/> Male <input type="checkbox"/> Female Case Number _____ | Client ID Number _____ Disability ID Number _____ SSN (last four digits) _____ |
|---|---|--|--|

Section I – Medical Report – Note to Provider

This individual has made an application (reapplication) for Disability Medicaid. Your cooperation in completing this form to show the individual's current condition, focusing on both remaining capabilities and limitations, is requested. Your promptness will ensure an early decision on the individual's application.

Please return the completed form to the agency in Section I above, along with a copy of all medical records for the past 12 months.

Diagnosis(es) _____ Date of last exam _____
 _____ Height _____ ft. _____ in.
 _____ Weight _____ lbs.

Exertional Functions. Please indicate what the individual is CAPABLE of doing:

| Lifting | Carrying | Standing | Walking | Sitting | Pushing | Pulling |
|---|---|---------------------------------------|---------------------------------------|---------------------------------------|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> < 10 lbs. | <input type="checkbox"/> < 10 lbs. | <input type="checkbox"/> < 2 hrs./day | <input type="checkbox"/> < 2 hrs./day | <input type="checkbox"/> < 6 hrs./day | <input type="checkbox"/> Using R arm | <input type="checkbox"/> Using R arm |
| <input type="checkbox"/> Max. 10 lbs. | <input type="checkbox"/> Max. 10 lbs. | <input type="checkbox"/> 2 hrs./day | <input type="checkbox"/> 2 hrs./day | <input type="checkbox"/> 6 hrs./day | <input type="checkbox"/> Using L arm | <input type="checkbox"/> Using L arm |
| <input type="checkbox"/> Max. 20 lbs./freq. 10 lbs. | <input type="checkbox"/> Max. 20 lbs./freq. 10 lbs. | <input type="checkbox"/> 6 hrs./day | <input type="checkbox"/> 6 hrs./day | | <input type="checkbox"/> Using R leg | |
| <input type="checkbox"/> Max. 50 lbs./freq. 25 lbs. | <input type="checkbox"/> Max. 50 lbs./freq. 25 lbs. | | | | <input type="checkbox"/> Using L leg | |
| <input type="checkbox"/> > 50 lbs. | <input type="checkbox"/> > 50 lbs. | | | | | |

Non-Exertional Functions. Please check if LIMITATIONS exist in any of the areas below:

| Sensory | Postural | Manipulative | Environmental | Mental |
|---|--|--|--|---|
| <input type="checkbox"/> No Limitations | <input type="checkbox"/> No Limitations | <input type="checkbox"/> No Limitations | <input type="checkbox"/> No Limitations | <input type="checkbox"/> No Limitations |
| <input type="checkbox"/> Seeing | <input type="checkbox"/> Stooping/Bending | <input type="checkbox"/> R Upper Extremity | <input type="checkbox"/> Tolerating dust, fumes, extremes of temperature | <input type="checkbox"/> Understanding, carrying out, remembering instructions |
| <input type="checkbox"/> Hearing | <input type="checkbox"/> Crouching/Squatting | <input type="checkbox"/> L Upper Extremity | <input type="checkbox"/> Tolerating exposure to heights or machinery | <input type="checkbox"/> Making simple work-related decisions |
| <input type="checkbox"/> Speaking | <input type="checkbox"/> Climbing | | <input type="checkbox"/> Operating a motor vehicle | <input type="checkbox"/> Responding appropriately to supervision, co-workers, work situations |
| | | | | <input type="checkbox"/> Dealing with changes in a routine work setting |

| | | |
|--------------------------|----------------------|---------------------------|
| Provider Signature _____ | Print Name _____ | Date Signed _____ |
| Specialty _____ | Office Address _____ | Office Phone Number _____ |