Human Resources Administration
Department of Social Services

Medical Insurance and Community Services Administration (MICSA)

MEDICAID ALERT

January 24, 2013

Medical Evidence Gathering for Adult Disability Determinations

The New York State Department of Health has modified the process to be followed to gather medical information for adult disability determinations. Both the LDSS-1151 and LDSS- 486T forms have been modified –and a requirement for submission of medical records has been added.

LDSS 1151 Disability Questionnaire

The LDSS-1151 was renamed to Disability Questionnaire to reflect the fact that this form is often mailed to a recipient and may not involve an interview. The form has also been substantially revised to be more user friendly as well as to collect additional information needed to appropriately determine a disability. This form **must** be completed in its entirety and **must** include the Applicant/Recipients SSI/SSDI history (including date of application and decision date, reason for denial, and appeal date, if applicable) and work and education history.

LDSS-486T Medical Report for Determination of Disability

The LDSS-486T has been significantly shortened. It **must** be completed by each of the Applicant/Recipient's treating providers. Additionally, applicable medical records for the applicant/recipient (e.g. progress notes, testing reports, hospital discharge reports, etc) **must** also be included for the most recent 12 months, or for the desired disability determination timeframe.

Submitters are requested to begin using the revised LDSS-1151 and LDSS-486T immediately. Please be advised, however, that the older versions **will not be accepted** past February 28, 2013. Links to the revised forms are available on MARC – or directly on the SDOH web-site.

Signed HIPAA Releases

We are also requesting that submitters include 3 HIPAA OCA 960 forms signed and dated by the consumer. These forms will facilitate HRA's ability to request additional information from treating providers, if necessary. This will help ensure a timely disability determination.

NYC Medicaid Alerts are a Periodic Service of the NYC Human Resources Administration
Medical Assistance Program• Office of Eligibility Information Services • 330 West 34th Street, New York, NY 10001
Robert Doar, ***Administrator/Commissioner*** **♦ Mary Harper,** ***Executive Deputy Commissioner*** **♦Maria Ortiz-Quezada***, Director of EIS*

EDITs submitters

EDITS submitters **must** submit the LDSS-486T, medical records, and signed HIPAA releases as a single file, using the correct document type for the LDSS-486T. The correct document type is:

- LDSS 486T, Medical Report for Determination of Disability Doc Category: 13 Doc Type: 5481

Submitters are reminded that the correct document type for the LDSS 1151, Disability Questionnaire is:

- LDSS 1151 Disability Questionnaire Doc Category: 13 Doc Type: 5480

It is critical that submitters use the correct Doc Types for these forms. HRA has developed an automated interface from EDITS to our Disability Services Program. This interface is based on Doc Type. If disability documents are submitted without the proper Document Types their submission for review could be significantly delayed or an adverse decision rendered.

AGENCY/ADDRESS:

DISABILITY QUESTIONNAIRE

NEW YORK STATE **DEPARTMENT OF HEALTH**

Name (Last, First, Middle)	**TO BE COMPLETED BY LOCAL AGENCY:**
	Case Number: _____
	Client Identification Number: _____
	Medicaid application date: _____
	Ineligible without disability review? ☐ Yes ☐ No
Social Security Number (last 4 digits)_____	Family Health Plus eligible? ☐ Yes ☐ No
Date of Birth: ____/___/____	Medicaid Waiver? ☐ Yes ☐ No
Telephone No.: ( ) _____/_____	Waiver type: _____
Have you ever applied to the Social Security Administration (SSA) for disability benefits? ☐ Yes ☐ No	
If "Yes", when? (month/year) _____	SSA decision date: (month/year) _____
What was the decision?	
If denied for benefits, what was the reason (medical or non-medical)?	
Did you appeal the decision? ☐ Yes ☐ No	If "Yes", when? (month/year) _____

PART I – INFORMATION ABOUT YOUR MEDICAL CONDITIONS

A. Please list all of your medical conditions (diagnoses):

B. How do your medical conditions affect your ability to function? (Please include any limitations in your ability to perform activities of daily living and work-related activities.)

C. Please list your medications (or attach a list).

PART II – INFORMATION ABOUT YOUR MEDICAL RECORDS

In order to make a disability determination, current medical evidence is needed to evaluate your physical and/or mental impairments. If you have not seen a medical provider for your impairment(s) within the past 12 months, a consultative exam may be arranged for you by the local agency.

A. Do you have a primary care provider? ☐ Yes ☐ No
(If "Yes", please provide name, address, phone number.)

Date of last visit (month/year): _____

B. Have you seen any other medical provider(s) within the past 12 months? ☐ Yes ☐ No
(If "Yes", please complete the section below.)

Please list the name, address, and phone number of all medical providers you have seen for the past 12 months (for example, physicians, nurse practitioners/physician assistants, mental health counselors, physical/occupational/speech therapists, audiologists, etc.). (Continuation sheets are available.)

NAME	ADDRESS	PHONE NO.	REASON FOR SEEING:

C. Have you received medical care in a hospital or other health care facility within the past 12 months? ☐ Yes ☐ No
(If "Yes", please complete the section below.)

Please list the name and address of all hospitals and other medical facilities at which you have sought treatment in the past 12 months. (Continuation sheets are available.)

Hospital/Facility	Address	Reason:

D. Have you received services from any agencies to assist you with your impairment(s) within the past 12 months?
☐ Yes *(If "Yes", please complete the section below.)*
☐ No

Please list the name and address of any other agencies that you have seen for assistance with your medical conditions in the past 12 months (for example, vocational rehabilitation agencies, supported employment or housing agencies, case management agencies, etc.).

Name	Address	Reason:

PART III – INFORMATION ABOUT YOUR EDUCATION, LITERACY AND ABILITY TO COMMUNICATE IN ENGLISH (*Complete ONLY if you are an adult, age 18 or over.)*

If a disability determination cannot be made based on your medical conditions alone, the factors of education, literacy, ability to communicate in English, and work history will be used to determine disability.

A. What is the highest grade level of schooling that you have completed? _____

B. Were (are) you involved in Special Education classes in school? ☐ Yes ☐ No

C. Did (do) you receive any special help or accommodations in school? ☐ Yes ☐ No
(If "Yes", please describe.)

D. Have you received any vocational training or additional education within the past 12 months? ☐ Yes ☐ No
(If "Yes", please describe.)

E. Can you read a simple message in English (such as simple instructions, or a list of items)? ☐ Yes ☐ No

F. Can you write a simple message in English? ☐ Yes ☐ No

G. If English is not your primary language, please answer the next 3 questions:

1. Can you understand a simple message spoken in English?

2. Can you speak a simple message in English?

3. Was assistance or an interpreter necessary to complete this application?
(If "Yes", please describe.)

PART IV – INFORMATION ABOUT WORK YOU DID IN THE PAST 15 YEARS

In as much detail as possible, please list jobs (up to 5) that you performed in the past 15 years, starting with your most recent job. Be sure to complete all portions to the best of your ability.

Dates of Employment:	**Job Title:**	**Type of Business:**
From: ________________ **To:** ________________		
	Number of hours/week: __________	**Rate of Pay:** __________
Describe your basic duties:		
During a typical day, how many hours did you: Stand__________ Walk__________ Sit__________		
How much did you frequently lift? _________ pounds		
Reason for leaving:		

Dates of Employment:	**Job Title:**	**Type of Business:**
From: ________________ **To:** ________________		
	Number of hours/week: __________	**Rate of Pay:** __________
Describe your basic duties:		
During a typical day, how many hours did you: Stand__________ Walk__________ Sit__________		
How much did you frequently lift? _________ pounds		
Reason for leaving:		

Dates of Employment:	**Job Title:**	**Type of Business:**
From: ________________ **To:** ________________		
	Number of hours/week: __________	**Rate of Pay:** __________
Describe your basic duties:		
During a typical day, how many hours did you: Stand__________ Walk__________ Sit__________		
How much did you frequently lift? _________ pounds		
Reason for leaving:		

Dates of Employment:	Job Title:	Type of Business:
From: _____ To: _____		
	Number of hours/week: _____	Rate of Pay: _____
Describe your basic duties:		
During a typical day, how many hours did you: Stand_____ Walk_____ Sit_____		
How much did you frequently lift? _____ pounds		
Reason for leaving:		

Dates of Employment:	Job Title:	Type of Business:
From: _____ To: _____		
	Number of hours/week: _____	Rate of Pay: _____
Describe your basic duties:		
During a typical day, how many hours did you: Stand_____ Walk_____ Sit_____		
How much did you frequently lift? _____ pounds		
Reason for leaving:		

PART V – AGENCY COMMENTS

Name of Agency Worker reviewing this form:	Date:

LDSS-486T (6/12)

MEDICAL REPORT FOR DETERMINATION OF DISABILITY

NEW YORK STATE DEPARTMENT OF HEALTH

SECTION I – IDENTIFICATION (To Be Completed by Submitting Agency)

AGENCY'S NAME AND ADDRESS:	PATIENT'S NAME *(Last, First, Middle):*	CASE NUMBER:	
	PATIENT'S ADDRESS *(Street, City, State & Zip Code):*	SOCIAL SECURITY NUMBER:	
		SEX: ☐ MALE ☐ FEMALE	DATE OF BIRTH:

SECTION II – MEDICAL REPORT – NOTICE TO PHYSICIAN

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:
☐ < 10 lbs.	☐ < 10 lbs.	☐ < 2 hrs./day	☐ < 2 hrs./day	☐ < 6 hrs./day	☐ Using R arm	☐ Using R arm
☐ Max. 10 lbs.	☐ Max. 10 lbs.	☐ 2 hrs./day	☐ 2 hrs./day	☐ 6 hrs./day	☐ Using L arm	☐ Using L arm
☐ Max. 20 lbs./freq. 10 lbs.	☐ Max. 20 lbs./freq. 10 lbs.	☐ 6 hrs./day	☐ 6 hrs./day		☐ Using R leg	
☐ Max. 50 lbs./freq. 25 lbs.	☐ Max. 50 lbs./freq. 25 lbs.				☐ Using L leg	
☐ > 50 lbs.	☐ > 50 lbs.					

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

Sensory: ☐ No Limitations	Postural: ☐ No Limitations	Manipulative: ☐ No Limitations
☐ Seeing	☐ Stooping/Bending	☐ R Upper Extremity
☐ Hearing	☐ Crouching/Squatting	☐ L Upper Extremity
☐ Speaking	☐ Climbing	

Environmental: ☐ No Limitations	Mental: ☐ No Limitations
☐ Tolerating dust, fumes, extremes of temperature	☐ Understanding, carrying out, remembering instructions
☐ Tolerating exposure to heights or machinery	☐ Making simple work-related decisions
☐ Operating a motor vehicle	☐ Responding appropriately to supervision, co-workers, work situations
	☐ Dealing with changes in a routine work setting

Signature of Physician:	(Print Name):	Date Signed:
Specialty:	Office Address:	Office Phone Number:

PLEASE RETURN THIS FORM ALONG WITH A COPY OF ALL MEDICAL RECORDS FOR THE PAST 12 MONTHS.

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

- ❑ Medical Record from (insert date) _____ to (insert date) _____
- ❑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ❑ Other: _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ❑ By initialing here _____ I authorize _____ _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ❑ At request of individual ❑ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

Instructions for the Use of the HIPAA-compliant Authorization Form to Release Health Information Needed for Litigation

This form is the product of a collaborative process between the New York State Office of Court Administration, representatives of the medical provider community in New York, and the bench and bar, designed to produce a standard official form that complies with the privacy requirements of the federal Health Insurance Portability and Accountability Act ("HIPAA") and its implementing regulations, to be used to authorize the release of health information needed for litigation in New York State courts. It can, however, be used more broadly than this and be used before litigation has been commenced, or whenever counsel would find it useful.

The goal was to produce a standard HIPAA-compliant official form to obviate the current disputes which often take place as to whether health information requests made in the course of litigation meet the requirements of the HIPAA Privacy Rule. It should be noted, though, that the form is optional. This form may be filled out on line and downloaded to be signed by hand, or downloaded and filled out entirely on paper.

When filing out Item 11, which requests the date or event when the authorization will expire, the person filling out the form may designate an event such as "at the conclusion of my court case" or provide a specific date amount of time, such as "3 years from this date".

If a patient seeks to authorize the release of his or her entire medical record, but only from a certain date, the first two boxes in section 9(a) should both be checked, and the relevant date inserted on the first line containing the first box.