Human Resources Administration
Department of Social Services

Medical Insurance and Community Services Administration (MICSA)

MEDICAID ALERT

April 9, 2019

Disability Determination Packet Update and Appropriate DOC TYPE for EDITS Submitters

The purpose of this Alert is to inform Hospitals, Client Representatives, Nursing Homes and Community Based Organizations to identify/update the correct forms to submit when seeking a disability determination for Adults and Children. These forms apply to all cases submitted either manually or via Edit.

For Edits submitters the Medicaid program is also identifying the appropriate Document type (DOC TYPE) for indexing these forms in EDITS.

As with all disability determinations, the submitting agency, in conjunction with the Applicant/Recipient (A/R) or their parent/guardian, must attempt to obtain all available medical information from the A/R's treating sources, in order to help establish a longitudinal medical history. Information should cover the timeframe for which a disability determination is being considered, and at a minimum, 12 months immediately prior to the application date. The required forms are listed below. Additional medical documentation may also be submitted to support the disability determination.:

Adult Disability Referrals:

- **Required:**
  - **LDSS 1151 Disability Questionnaire** completed by A/R, parent, guardian or representative (DOC ID 7946)
  - **LDSS 486T Medical Report for Determination of Disability** (DOC ID 7945)
  - **MAP-252F, AIDS or AIDS Related Complex Medical Report** (only required if there is an AIDS diagnosis) (DOC ID 7951)
  - **MAP-751E Authorization to Release Medical Information** (DOC ID 6935) **This form is now required for all disability determination requests (**see attached).
  - **OCA 960 Authorization to Release Health Information Pursuant to HIPAA** – (**Now Required** only for all pooled trust referrals for A/R aged 65 or older). (DOC ID 7908)
- **Optional**
  - Additional Medical Documentation (if available)
    - Medical Records (DOC ID 7215)

- Doctor's Records (DOC ID 7438)
- Statement from Medical Professional (DOC ID 102)
- Mental Health Evaluation (DOC ID 9682)

Child/Children Disability Referrals:

- **Required**
  - **DOH 5139 Disability Questionnaire** (DOC ID 1165) **This form replaces the LDSS 1151** (see attached DOH 5139).
  - **OHIP-0005 Childhood Medical Disability Form** (DOC ID 9041)
  - **OHIP-0006 Questionnaire of School Performance** (DOC ID 9042)
  - **OHIP-0007 Description of Child's Activities** (DOC ID 9043)
  - **MAP-751E Authorization to Release Medical Information** (DOC ID 6935) **This form is now required for all disability determination requests.**

- **Optional**
  - Additional Medical Documentation (if available)
    - Medical Records (DOC ID 7215)
    - Doctor's Records (DOC ID 7438)
    - Statement from Medical Professional (DOC ID 102)
    - Mental Health Evaluation (DOC ID 9682)

Failure to provide the required documentation or failure to index documents with the correct DOC ID will result in delays in the referral process. These forms are all posted in MARC (access form file in your submitter type).

PLEASE SHARE THIS ALERT WITH ALL APPROPRIATE STAFF

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

NYC Human Resources Administration
Department of Social Services

MAP-751e (E) 06/06/2012

INFORMATION ABOUT MEDICAL OR OTHER SOURCE - PLEASE PRINT, TYPE, OR WRITE CLEARLY	
NAME AND ADRESS OF SOURCE (include Zip Code)	RELATIONSHIP TO DISABLED PERSON

INFORMATION ABOUT DISABLED PERSON - PLEASE PRINT, TYPE, OR WRITE CLEARLY		
NAME AND ADDRESS (if known) AT THE TIME DISABLED PERSON HAD CONTACT WITH SOURCE (Include Zip Code)	DATE OF BIRTH	DISABLED PERSON'S I.D. NUMBER (If known and if different than SSN.)
APPROXIMATE DATES OF DISABLED PERSON'S CONTACT WITH SOURCE (e.g., date of hospital admission, treatment, discharges, etc.)		

I hereby authorize the above named source to release or disclose to the Medical Assistance Program for re-disclosure in connection with my application for public health insurance.

1) All medical records or other information regarding my treatment, hospitalization, and/or outpatient care of my impairment(s), including psychological or psychiatric impairment(s) drug abuse, alcoholism, sickle cell anemia, acquired immunodeficiency syndrome (AIDS), or test for infection with human immunodefiency virus (HIV).

2) Information about how my impairment(s) affects my ability to complete tasks and activities of daily living.

3) Information about how my impairment(s) affected my ability to do work.

I understand that this authorization, except for action already taken, may be voided by me at anytime. If I do not void this authorization, it will automatically end at the conclusion of any proceedings, administrative or judicial, in connection with my Medicaid application, including any appeals. If I am already receiving benefits, the authorization will end when a final decision is made as to whether I can continue to receive benefits.

SIGNATURE OF DISABLED PERSON OR PERSON AUTHORIZED TO ACT IN HIS/HER BEHALF	RELATION TO DISABLED PERSON (If other than self)	DATE
STREET ADDRESS	TELEPHONE NUMBER (include area code)	
CITY	STATE	ZIP CODE

NEW YORK STATE DEPARTMENT OF HEALTH
State Disability Review Unit

Disability Questionnaire

COMPLETED BY THE STATE DISABILITY REVIEW UNIT:

NAME:

First: _____

Middle: _____

Last: _____

Social Security Number (last 4 digits): _____

Date of Birth: _____

Telephone No: _____

Case Number: _____

Client ID Number (CIN): _____

Disability ID Number (DIN): _____

Medicaid application date: _____

Medicaid Waiver? ☐ Yes ☐ 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:	Phone Number:	Address:
Reason for seeing:		
Name:	Phone Number:	Address:
Reason for seeing:		
Name:	Phone Number:	Address:
Reason for seeing:		

C. Have you received medical care in a hospital or other medical 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.)

Name:	Address:
Reason:	
Name:	Address:
Reason:	
Name:	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:	
Name:	Address:
Reason:	
Name:	Address:
Reason:	

PART III – INFORMATION ABOUT YOUR EDUCATION, LITERACY AND ABILITY TO COMMUNICATE IN ENGLISH

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. If you are age 21 or under and are attending school or a vocational program, please provide the school or program's name and address.

School/Program Name: _____

Address: _____

_____

Please complete the DOH-5173, Authorization for Release of Medical Information Pursuant to HIPAA form for this school/program.

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

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

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

(If you have a copy of your IEP, please include it with the returned form.)

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

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

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

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

1. Can you understand a simple message spoken in English? ☐ Yes ☐ No
2. Can you speak a simple message in English ☐ Yes ☐ No?
3. Was assistance or an interpreter necessary to complete this application? ☐ Yes ☐ No
   (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:

For Office Use:

Name of Reviewer:	Date: