Date Signed Application Received in Local Department **MUST BE DATE STAMPED**

MARYLAND DEPARTMENT OF HUMAN RESOURCES
FAMILY INVESTMENT ADMINISTRATION

APPLICATION PART II: Eligibility Determination Document For One Person

PLEASE PRINT ALL ANSWERS

☐**I wish to apply for:** ☐ Cash Assistance ☐Medical Assistance ☐ Food Stamps ☐Other, list:_____	☐**I am currently receiving:** ☐Cash Assistance ☐Medical Assistance: ID#_____ ☐Food Stamps ☐ Other, list:_____	Do you have unpaid medical bills now? ☐YES ☐NO

1. IDENTIFYING INFORMATION

Last Name	First Name	Middle Name	Jr., III, etc.	Maiden/Other Name

What language do you speak?	Do you need an interpreter? ☐YES ☐NO
Are you visually impaired ☐YES ☐NO	Are you hearing impaired? ☐YES ☐NO

2. ADDRESS Where do you live?

Number Street	Apt No.	Floor No.	Telephone Number
City	State	Zip Code + 4	Number where you can be reached during the day

3. MAILING ADDRESS *(IF DIFFERENT)*

Number Street	Apt. No.	Floor No.	Telephone Number

P.O. Box	City	State	Zip Code + 4

4. PREVIOUS ADDRESSES

Number Street	City	State	Zip Code + 4

When did you live there?	From	To	Did you own this home? ☐YES ☐NO

5. AUTHORIZED REPRESENTATIVE *(IF DESIRED)*

First Name	Middle Name	Last Name	Jr., III, etc.

Number Street	City	State	Zip Code + 4

Telephone Number	Relationship to you

Check what you want the representative to do:

☐Complete interview for you ☐Sign your application ☐ Cash your check ☐ Cash your Food Stamps ☐ Receive your notices ☐ Receive your Medical Assistance Card

FOR WORKER USE ONLY	LDSS Office	Programs Applied For / Receiving	Assistance Unit ID's
	Worker's Name		Client ID
	Application/Redetermination Date		

6. INDIVIUAL INFORMATION Complete the section below.

Last Name	First Name	Middle Name	Jr.,III etc.

Maiden/Other Name	Social Security Number	List Additional Social Security Number	Date of Birth

Sex ☐Male ☐Female	Race * (Optional)		

Resident of Maryland ☐YES ☐NO	Marital Status	Due date if pregnant	Number expected	Receiving Prenatal Care? ☐YES ☐NO

Receiving benefits in another state:
Public Assistance? ☐YES ☐NO Food Stamps? ☐YES ☐NO Medical Assistance? ☐YES ☐NO

U.S. Citizen? ☐YES ☐NO	Student? ☐YES ☐NO	On Strike? ☐YES ☐NO	Disabled or Incapacitated? ☐YES ☐NO	Medical Insurance? ☐YES ☐NO	Medicare Part A ☐YES ☐NO	Medicare#

7. MIGRANT WORKER

Are you a migrant worker?
☐YES ☐NO

8. BOARDER If you are a boarder, fill in this sections:

Number of Meals per Day	Cost of Meals per Month $

9. CITIZENSHIP if you are not a United States citizen, fill in this section

INS Status	Newly Legalized Status Date	Sponsored Alien ☐YES ☐NO	Country of Origin

US Entry Date	INS Number	

10. SCHOOL if you are in school, fill in this section:

Student Status ☐Full-time ☐Half-time ☐Less than half-time	Educational Level ☐Elementary ☐College ☐Secondary ☐Other, List:_____	Highest Grade Completed Expected Graduation Date (*If in high school*)

School Name	School Number

School Address City State Zip Code + 4

11. DISABILITY If you are disabled or incapacitated, what is the disability?

12. MEDICAL INSURANCE If you have medical insurance, fill in this section:

Policy Number	Group Number	Policy Holder Name

Relationship to Policy Holder

FOR WORKER USE ONLY	Financial Responsibility Penalty Type Penalty Date Special Needs (NEED)

12. MEDICAL INSURANCE (continued)

POLICY HOLDER ADDRESS

Number Street			
City	State	Zip Code + 4	Telephone Number

INSURANCE COMPANY

Insurance Company Name			
Number Street			
City	State	Zip Code + 4	Telephone Number

UNION

Union Name		Union Local Number
Number Street		
City	State	Zip Code + 4	Telephone Number

13. VETERAN INFORMATION If you are a veteran or a disabled widow or widower, or a disabled child of a deceased veteran, fill in this section:

Veteran's Name	Relationship to Veteran	Veteran's Status	Military Service Number

14. MEDICAL EXPENSE

If you are 60 or older, blind or disabled and applying for or receiving Food Stamps, do you have medical bills that you must pay?

☐YES ☐NO *If Yes, bring in your bills.*

15. LIQUID ASSETS Complete for assets as of the 1st day of the month. Check Yes or No for each ASSET TYPE

ASSET TYPE	CHECK ONE	OWNER	AMOUNT Balance/value	ACCOUNT NUMBER	FDIC NUMBER	INSTITUTION
Cash on Hand	☐YES ☐NO		$	N/A	N/A	N/A
Checking Accounts	☐YES ☐NO		$			
Savings Accounts	☐YES ☐NO		$			
Credit Union Accounts	☐YES ☐NO		$			
Trust Funds	☐YES ☐NO		$			
IRA or Keogh Accounts	☐YES ☐NO		$			
Stocks, bonds, Certificates, Money Market Funds, treasury or Other Notes	☐YES ☐NO		$			
Annuities:	☐YES ☐NO		$			
Other, List:	☐YES ☐NO		$			
Other, List	☐YES ☐NO		$			
Other, List	☐YES ☐NO		$			
Other, List	☐YES ☐NO		$			
Other, List	☐YES ☐NO		$			

LIFE INSURANCE AND FUNERAL PLANS If you have any life insurance or pre-paid burial plans or funds, full in this section. List all policies and plans no matter who pays for them.

NAME OF PERSON WHO PAYS	ORIGINAL FACE VALUE OR VALUE OF PLAN	CURRENT CASH VALUE	POLICY NUMBER OR ACCOUNT NUMBER	LIFE INSURANCE OR BURIAL PLAN	COMPANY, FUNERAL HOME OR BANK NAME
	$	$			
	$	$			

17. REAL PROPERTY If you own property, fill in this section. Include burial plots.

Number Street	City	State	Zip Code + 4
How Used?	Current Fair Market	Amount Owed Now	Trying to Sell ☐YES ☐NO
Number Street	City	State	Zip Code + 4
How Used?	Current Fair Market	Amount Owed Now	Trying to Sell ☐YES ☐NO

18. OTHER ASSETS If you own other assets not listed, such as antiques, boat, recreational vehicle, coin collections, furs, jewelry, livestock, or stamp collections, fill in this sections:

ASSET TYPE	CURRENT FAIR MARKET VALUE	AMOUNT OWED
	$	$
	$	$

19. POTENTIAL ASSET OR INCOME If you are expecting to receive an accident settlement, trust fund, inheritance or other money or property, full in this section.

Type	Lawyer Name
Explanation	Lawyer Telephone

20. TRANSFER OF ASSETS if you sold, traded or gave any property, motor vehicles, stocks, bonds, cash or other assets in the past 3 years (5 years for a trust), fill in this sections:

Transfer Date	Who Received the Asset?	Type of Assets
Fair Market Value When Transferred	Amount Received	Reason for Transfer

21. INCOME FROM WORKING If you are working now, fill in this section. If not, list the last job held. Include full-time, part-time or temporary work or self-employment, such as owning a business, roomer or boarder income, babysitting, home demonstrations, cleaning houses, etc.

Employer Name						
Employer Address- Number Street City State Zip Code + 4					Telephone	Type of Job
Date Job Began	Date Job Ended	Reason for Leaving	Date Last Pay Received if Job Ended		Gross Wages before deductions per Pay Period (*include tips, commissions*) $	
Hours Per Pay Period	How Often Paid?	If Income from Boarders, How Many Boarders?		Self-employment or Handicapped work Expenses	Type	
					Amount	$ $

Employer Name						Federal ID
Employer Address Number Street City State Zip Code+4					Telephone	Type of Job
Date Job Began	Date Job Ended	Reason for Leaving	Date Last Pay Received If Job Ended		Gross Wages before deduction per Pay Period (include tips, commissions) $	
Hours per Pay Period	How Often Paid?	If Income from Boarders, How Many Boarders?		Self-employment or Handicapped Work Expenses	Type	
					Amount	$ $

22. OTHER INCOME AND BENEFITS Check if you are receiving, have applied for or have been denied any of the following:

TYPE OF BENEFIT	RECEIVING BENEFITS	AMOUNT	APPLICATION STATUS	APPLICATION OR DENIAL DATE
Alimony	☐YES ☐NO	$	☐Applied for ☐Denied	
Child Support	☐YES ☐NO	$	☐Applied for ☐Denied	
Social Security Claim #:	☐YES ☐NO	$	☐Applied for ☐Denied	
SSI Claim #:	☐YES ☐NO	$	☐Applied for ☐Denied	
Railroad Retirement Benefits Claim#:	☐YES ☐NO	$	☐Applied for ☐Denied	
Veteran's Pension/Benefits	☐YES ☐NO	$	☐Applied for ☐Denied	
Unemployement Benefits	☐YES ☐NO	$	☐Applied for ☐Denied	
Worker's Compensation	☐YES ☐NO	$	☐Applied for ☐Denied	
Pension or Retirement	☐YES ☐NO	$	☐Applied for ☐Denied	
Disablility/Sick/Maternity Benefits	☐YES ☐NO	$	☐Applied for ☐Denied	
Union Benefits	☐YES ☐NO	$	☐Applied for ☐Denied	
Military Allotment	☐YES ☐NO	$	☐Applied for ☐Denied	
HUD Section 8 Utility Benefits/Supplements	☐YES ☐NO	$	☐Applied for ☐Denied	
Money from Friends or Relatives (loans & other)	☐YES ☐NO	$	☐Applied for ☐Denied	
Money from Rental income	☐YES ☐NO	$	☐Applied for ☐Denied	
Black Lung Benefits	☐YES ☐NO	$	☐Applied for ☐Denied	
Lump Sum Amounts	☐YES ☐NO	$	☐Applied for ☐Denied	
Civil Service Annuity	☐YES ☐NO	$	☐Applied for ☐Denied	
Public Assistance/State Disability Benefits from Another State	☐YES ☐NO	$	☐Applied for ☐Denied	
Interest or Dividends from Stocks, Bonds, Savings, or Other Investments	☐YES ☐NO	$	☐Applied for ☐Denied	
Other Income (*not listed above*) Specify _____	☐YES ☐NO	$	☐Applied for ☐Denied	
Other Income (*not listed above*) Specify _____	☐YES ☐NO	$	☐Applied for ☐Denied	

23. WORK REGISTRATION/PARTICIPATION FOR FOOD STAMP AND REFUGEE ASSISTANCE ONLY Certain applicants over 16 must register and participate in a work program. The work programs are the Food Stamp Employment and Training Program and the Refugee work Registration Program. You may not have to participant if you have a good reason. You may volunteer if you do not have to participate. Fill in this section.

Wish to volunteer? ☐YES ☐NO	Reason **NOT** able to participate?

24. SHELTER COSTS Are you paying for any of the following? Complete only if you are applying for Food Stamps

Expenses	Check One	Amount	How Often Paid?	Who Pays?	Expenses	Check One	Amount	How Often Paid?	Who Pays?
Rent	☐YES☐NO	$			Sewer	☐YES☐NO	$		
Mortgage	☐YES☐NO	$			Garbage	☐YES☐NO	$		
Electric	☐YES☐NO	$			Coop/ Condo Fee	☐YES☐NO	$		
Oil	☐YES☐NO	$			Homeowner Insurance (if not included in mortgage)	☐YES☐NO	$		
Gas	☐YES☐NO	$				☐YES☐NO	$		
Property Taxes	☐YES☐NO	$			Other Utility Cost, list	☐YES☐NO	$		
Telephone	☐YES☐NO	$			Other Utility Cost, list	☐YES☐NO	$		
Water	☐YES☐NO	$			Other Utility Cost, list	☐YES☐NO	$		

Do you live in: ☐Public Housing ☐Section 8 Housing ☐FMHA 515 Housing ☐Private Housing

Do you receive a Utility Supplement? ☐YES ☐NO

Is heat included in the rent? ☐YES ☐NO

If heat is not included in the rent, Check the main source of heat:

☐Oil ☐Gas
☐Electric ☐Coal
☐Wood ☐Kerosene
☐Propane ☐Other, list:

Do you pay for lights or cooking? ☐YES ☐NO
Check any other source(s) of heat:

☐Oil ☐Gas
☐Electric ☐Coal
☐Wood ☐Kerosene
☐Propane ☐Other, list

If you are sharing any of the costs listed above, fill in this section:

TYPE OF EXPENSES SHARED	WITH WHOM	TOTAL AMOUNT OF SHARED EXPENSES	AMOUNT OF YOUR SHARE
		$	$
		$	$

25. ADDITIONAL INFORMATION

YOUR RIGHTS AND RESPONSIBILITIES

YOU HAVE THE FOLLOWING RIGHTS

RIGHT TO WRITTEN NOTICE – We must always give you a written notice explaining your benefits when we approve your case. We must always give you written notice when we change your benefits, deny or close your case. You have 90 days from the notice date to ask for a hearing. If you ask for a hearing **within 10 days**, you may be able to keep getting benefits while you wait for the hearing.

RIGHT TO APPEAL - Ask for a hearing if you disagree with the Department's decision. Your case manager can help you write your appeal. At the hearing, you can speak for yourself or bring a lawyer, friend or relative to speak for you. You may call the Department at 1-800-332-6347 for help to request a hearing.

EQUAL RIGHTS – Federal law and U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS) policy state we can not discriminate against you because of race, color, national origin, sex, age, or disability. Under the Food Stamp act and USDA policy, we also cannot discriminate against you because of religion or political beliefs.

If you think we have discriminated against you, contact USDA or HHS. Write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410 or call (202) 720-5964 (voice and TDD). Write HHS, Director, Office for Civil Rights, Room 506-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (202) 619-3257 (TDD). USDA and HHS are equal opportunity providers and employers.

RIGHT TO PRIVACY – You are giving personal information in the application. We use the information to see if you are eligible for benefits. If you do not give information, we may deny your application. You have a right to review, change, or correct any information. We will not show your information or give it to others unless you give us permission or federal and state law allows us to do so.

RIGHT TO CLAIM GOOD CAUSE – If you want Temporary Cash Assistance (TCA), you must help the Department get child support. You may not have to help if it puts you or your family in danger.

RIGHT TO REFUSE HELP – You do not have to accept help from a religious organization if it is against your religious beliefs.

YOU HAVE THE FOLLOWING RESPONSIBILITIES

PROVIDE INFORMATION – You must give true and complete information. You must provide proof of this information. We will keep this information private.

Collecting application information, including the social security number of each household member, is authorized under the Food Stamp Act 1977 as amended, U.S.C. 2001-2036, Social Security Act 1137(F) and 42 U.S.C. 1320b –7 (d).. We use the information to find out if your household is eligible.

We also use the information to see if you meet program rules. We may contact your employer, bank or other party. We may also contact local, state or federal agencies to make sure the information is correct. We can give your information to other federal or state agencies for official use and to law enforcement officers who need it to find persons fleeing to avoid the law.

If you get too much in benefits, we may give the application information, including social security numbers, to federal or state agencies, as well as private claims collections agencies, for action.

Giving information is voluntary. If you do not give us information, including social security numbers, for everyone who wants help; we may deny benefits for each person who does not give a social security number. If you do not have a social security number, we will help you get one.

REPORT CHANGES – You must report all changes within 10 days unless you have a job and are part of the food stamp simplified reporting group and you are not receiving Cash Assistance or Medical Assistance. If you want to know if you are part of this group, ask your case manager. You may tell us about any changes in person, by telephone, or by mail to the Department.

YOUR RIGHTS AND RESPONSIBILITIES

WARNING – WE MAY DENY, LOWER OR STOP YOUR BENEFITS IF YOU GIVE US WRONG INFORMATION OR DO NOT REPORT CHANGES. A JUDGE MAY FINE AND/OR IMPRISON YOU IF YOU DELIBERATELY GIVE WRONG INFORMATION OR DO NOT REPORT CHANGES.

FOOD STAMP PENALTY – Household members shall not

- Give false information or withhold information to get or continue to get Food Stamps
- Trade or sell Food Stamps, or electronic benefits cards.
- Use Food Stamps to buy items not allowed, such as alcohol and tobacco.
- Use someone else's Food Stamp benefits.
- Use someone else's Electronic Benefits Card without authorization

Your food stamps will not increase if your cash assistance case is reduced or closed because you did not follow the rules.

If a household member deliberately breaks the rules, we may bar the person from the Food Stamp Program.

- We may bar this person for one year after the first violation.

- We may bar this person for two years:
  *After the second violation, or
  *After the first time a court finds this person guilty of buying illegal drugs with Food Stamps, or
  *After the first time a court finds this person guilty of buying guns, bullets, or explosives, with Food Stamps.
  *After a court finds this person guilty of trafficking food stamp benefits of $500 or more.

A judge can also fine this person up to $250,000, imprison the person for up to 20 years, or both. A judge can also bar this person for an additional 18 months. The person may also have to face further prosecution under other federal laws.

TCA PENALTY – If an assistance unit members is convicted of an Intentional Program Violation (IPV), everyone in your family will lose their benefits.

- The first time, you will lose your benefits for 6 months or until you repay all of the money.
- The second time, you will lose your benefits for 12 months or until you repay all of the money.
- The third time, you cannot get TCA benefits again.

MEDICAL ASSISTANCE WARNING AND PENALTY – Only use Medical Assistance cards if you are eligible.

Every person convicted of "Medical Assistance Fraud" with a value of $500 or more in money, services, or goods is guilty of a felony, and shall:

1. Pay back money, services or goods; of the value of those services or goods unlawfully received;
2. Be subject to a fine of a no more than $10,000, imprisoned for no longer that five years, or both.

Every person convicted of "Medical Assistance Fraud" with a value of less than $500 in money, services or goods is guilty of a misdemeanor, and shall:

1. Pay back money, service or goods; of the value of those service or goods unlawfully received;
2. Be fined no more than $1,000 and imprisoned for no longer than three years, or both.

YOUR RIGHTS AND RESPONSIBITIES

READ BEFORE SIGNING:

I understand that I can be fined, imprisoned or have my benefits reduced for making false statements or for pretending to be another person.

I also know I can be punished for not reporting changes that may affect my eligibility or benefit amount.

I know the Department can use the application against me in a court or law for fraud prosecution.

I know that failing to report to verify shelter, medical, or dependent care expenses or child support payments is the same as saying I do not want a deduction for the expense I did not verify or report.

I understand that the Department may select my case for a spot check.

I agree to allow someone from the Department to visit me at home. I will help them get all needed proofs from any source.

I agree that Medicare Part B will make payments directly to doctors and medical suppliers.

I give the Department the right to seek payment from private or public health insurance and any liable third party. I understand that must cooperate with the Department in securing such payments. The Department may seek payment without legal action, as long as it does not keep more than amount Medical Assistance paid.

I give the Department the right to inspect, review and copy all medical records for service received through the Medical Assistance Program.

I understand that when a person is deceased who was at least 55 years old when receiving Medical Assistance the state may take money from the estate to repay payments made on behalf of that person. The program may take the money only if there is no surviving spouse, unmarried child younger than 21, or blind or disabled child (married or unmarried) of any age.

SIGNATURE SECTION

I have read or someone has read and explained the entire application to me, I swear or affirm under penalty of perjury that all the information I gave is true, correct, and complete to the best of my ability, behalf and knowledge. I received a copy of my rights and responsibilities. I authorize any person, partnership, corporation, association, or governmental agency that know the facts about my eligibility to give that information to the Department. I also authorize the Department to contact any person, partnership, corporation, association, or governmental agency that has given proof of my eligibility for benefits. I certify, under penalty of perjury, that by signing my name below, all persons for whom I am applying are U.S. citizens or lawfully admitted immigrants.

Signature of Applicant/Recipient	Date
Signature of Witness (If you signed an X)	Date
Signature of Spouse (If Applicable)	Date
Signature of Authorized Representative (If Applicable)	Date
Signature of Case Manager	Date

I withdraw my application for: ☐ Cash Assistance ☐ Food Stamps ☐ Medical Assistance

Signature of Applicant, Recipient or Authorized Representative	Date

YOUR RIGHTS AND RESPONSIBLITIES

ASSIGNMENT OF SUPPORT RIGHTS FOR TEMPORARY CASH ASSISTANCE

- I assign to the State of Maryland all rights, titles, and interest in support that I may have for myself or for any person receiving TCA.
- This includes any overdue support that has been collected.
- I agree to send to the State of Maryland any support I receive. If I do not turn over this support, I will have to repay this amount to the State of Maryland. I may also be prosecuted for fraud.

When I am eligible for Medical Assistance:

- I assign all rights, title, and interest in medical support and health insurance payments I may have for myself or any person receiving Medical Assistance. This includes overdue medical support or health insurance payments that have not been collected.
- I agree to have the child support agency collect medical support payments owed to me and to keep up to the amount of Medical Assistance payments that have been made to me.
- I agree give the State of Maryland any medical support or health insurance payments I receive.
- I will cooperate to the best of my ability and knowledge with the child support agency while I am receiving TCA and Medical Assistance
- If I do not cooperate with the child support agency to the best of my ability and knowledge, I may lose all of my benefits and my case may be closed.

I HAVE READ THESE STATEMENTS OR SOMEONE HAS READ THEM TO ME. I UNDERSTAND WHAT THEY MEAN. BY SIGNING MY NAME BELOW, I AGREE TO FOLLOW WHAT THEY SAY.

Signature	Date

MEDICAL ASSISTANCE PROGRAM

VOCATIONAL, EDUCATIONAL, AND SOCIAL DATA

_____Department of Social Services

To be completed by applicant and reviewed during interview, with assistance from case manager as necessary.

Name	Social Security #		Alien Residency Date
Customer ID#	Date of Birth	Sex: M___ F___	Alien Status

PART 1: WORK HISTORY

What is the date you last worked? _____/_____/_____

List all jobs held in the last fifteen years. Begin with your most recent job. To list more jobs, use Part 9: COMMENTS**.**

Job Title	What You Did	Date Started	Date Ended	Hours Per Week	Reason for Leaving

In your usual job did you:	YES	NO	
Use machines, tools, or equipment of any kind?	____	____	
Use technical knowledge and skills?	____	____	
Do any writing, complete reports, etc.?	____	____	
Supervise other people	____	____	If yes, how many people?_____

Check the number of **HOURS** you performed the following physical activities in your usual job:

Activity	0	1	2	3	4	5	6	7	8
Bend									
Squat									
Crawl									
Reach									
Climb									

Activity	0	1	2	3	4	5	6	7	8
Sit									
Stand									
Walk									
Lift									
Carry									

Check the **HEAVIEST** weight lifted in your usual job.

___ Less than 10 lbs. __ 10 lbs. __25 lbs. __ 50 lbs. __ 100 lbs. __ More than 100 lbs.

Check the weight **FREQUENTLY** lifted/carried in your usual job.

___ 10 lbs. ___ 25 lbs. ___ 50 lbs. ___ more than 50 lbs.

Part 2: EDUCATION/TRAINING

Can you Speak English? __YES __ NO Can you Read English? __ YES __ NO Can you Write English? __ YES __NO

Circle the highest grade completed 1 2 3 4 5 6 7 8 9 10 11 12

Were you in any special education classes during high school? ___ YES ___ NO

Please check and give date received if one applies:

___High School Diploma ___High School Certificate ___GED Date Received___/_____/_____

Attended College From Dates ____/_____/_____ to ____/_____/_____Degree:_____

Have you had Vocational, Military, or Job Training? ___ YES ____ NO

Please describe the training:_____

List type of license or certificate_____Date:_____

Part 3: SOCIAL SECURITY DISABILITY/SSI BENEFITS

Have you applied for Social Security Disability and/or SSI benefits __ YES __ NO

___ I applied for benefits on this date: ___/___/___
Month Day Year

___ My application for SSI/SSDI is still pending

___ My application for SSI/SSDI was denied: ___/___/___
Month Day Year

___ I intend to file an appeal

___ I have filed an appeal: *Please check all that apply and give date filed*

___Reconsideration Date: ___/___/___
Month Day Year

___Hearing before Administrative Law Judge Date: ___/___/___
Month Day Year

___Appeals Council Date: ___/___/___
Month Day Year

PART 4: MEDICAL

What medical conditions prevent you from working? Please list all conditions. Briefly explain how your conditions keep you from working.

When did your conditions first bother you? Date: ___/___/___
Month Day Year

PART 5: INFORMATION ABOUT YOUR MEDICAL TREATMENT AND RECORDS

Have you been seen by a doctor/hospital/clinic or anyone else for the illnesses, injuries or conditions that limit your ability to work?
___ YES ____ NO

Have you been seen by a doctor/hospital/clinic or anyone else for emotional or mental health problems that limit your ability to work?
___ YES ____ NO

Please list your treatment sources for your physical and/or mental conditions. To list more sources, use Part 9: COMMENTS

NAME OF DOCTOR/MCO	ADDRESS	TELEPHONE	DATES & REASON FOR VISIT
			Starting Date: _____ Last Seen: _____ Reason: _____
			Starting Date: _____ Last Seen: _____ Reason: _____
			Starting Date: _____ Last Seen: _____ Reason: _____

NAME OF THERAPIST/COUNSELOR	ADDRESS	TELEPHONE#	DATES & REASON FOR VISIT
			Starting Date:_____ Last Seen:_____ Reason:_____
			Starting Date:_____ Last Seen:_____ Reason:_____
			Starting Date:_____ Last Seen:_____ Reason:_____
NAME OF HOSPITAL/CLINIC	**ADDRESS**	**TELEPHONE#**	**DATES & REASON FOR VISIT**
			Admission:_____ Discharge:_____ Reason:_____
			Admission:_____ Discharge:_____ Reason:_____
			Admission:_____ Discharge:_____ Reason:_____

MEDICATIONS: List all prescription and nonprescription medications that you now take, and their side effects, which may keep you from working, e.g. drowsiness and dizziness, etc. To list additional medications, use **Part 9: COMMENTS**

NAME OF MEDICATION	REASON FOR MEDICATION	SIDE EFFECTS

PART 6: BEHAVIORAL HEALTH

Do you have any of the following thoughts or feelings?

Thought/Feeling	YES	NO
Feel sad a lot of the time		
Have problems sleeping (too much or too little)		
Loss of interest in activities I usually like		
Feel guilty or worthless		
Changes in appetite (eat too much or to little)		
Feel or think people are trying to hurt me		
Loss of energy		
Much more energy than usual		

Thought/Feeling	YES	NO
Have panic attacks		
Have problems concentrating or thinking		
Hear voices when no one is there		
See things that others don't see		
Feel nervous or worried all the time		
Think of hurting myself		
Think of hurting others		
Feel hopeless or desperate		

PART 7: INFORMATION ABOUT YOUR ACTIVITIES

How often do you have DIFFICULTY doing the following? (Check: always, often, seldom, or never after each activity.)
Please check, if pain is associated with or affects your ability to engage in an activity)

ACTIVITY	ALWAYS	OFTEN	SELDOM	NEVER	AFFECTED BY PAIN
Sitting					
Standing					
Walking					
Bending					
Lifting					

ACTIVITY	ALWAYS	OFTEN	SELDOM	NEVER	AFFECTED BY PAIN
Grasping					
Reaching					
Pushing					
Pulling					

Taking care of yourself

Do you have any problems bathing? __ YES __ NO If, yes, please explain:_____
Do you have any problems dressing? __ YES__ NO If yes, please explain:_____
Describe any changes in taking care of yourself since you became unable to work:_____

Taking care of where you live

Do you live in an apartment ___ or house ___? Who lives with you?_____
Do you clean house, do odd jobs/chores around the house/yard? ___ YES___ NO
If yes, what do you do?_____
How often do you do these things?_____
How long does it take you to do these things?_____Do you need help? __ YES __ NO If yes, please explain:
Do you need to stop and rest? __ YES __NO If yes, explain why._____
Describe any changes in taking care of your household since you became unable to work:_____

Cooking

Do you prepare your own meals? __ YES __ NO If yes, which meals? __Breakfast __ Lunch __ Dinner
What kind of food do you usually prepare?_____
How often do you cook your own meals?_____
Do you need help? __ YES __ NO If yes, please explain:_____
Do you need to stop and rest? __YES __ NO How often do you need to rest?_____
Describe any changes in your cooking habits since you became unable to work:_____

Shopping

Do you go shopping? __ YES __ NO If yes, what kind of shopping do you do? (Groceries, clothing, etc):_____
How often do you shop?_____Do you need help shopping? __YES ___ NO
If yes, please explain:_____
Do you handle your own money? __ YES __ NO If no, please explain:_____
Describe any changes in your shopping habits since you became unable to work:_____

Going out in public

How do you get to places you need to go?_____
Can you drive? __ YES __NO If no, please explain:_____
How long can you drive without stopping and resting?_____
Do you need help when you go out? __ YES__ NO If yes, please explain:_____
Do you have problems walking or climbing stairs? __YES __NO If yes please explain:_____
Describe any changes in going out in public since you became unable to work:_____

Hobbies/Activities/Pastimes

What do you do in your spare time? (For example: reading, writing, gardening, sewing, watching TV)_____

How often do you do these things?_____
Do you need to stop and rest? __ YES __ NO If yes, please explain:_____
How often do you need to stop and rest? _____
Describe any changes in your hobbies and pastimes since you became unable to work:_____

Social Relationships

Do you go and visit people? __ YES__ NO If yes, how often?_____How long?_____
If no, please explain why you do not go out and visit with people:_____

Do you talk on the phone with other people __ YES__ NO If yes, how often?_____How long?_____
Describe any changes in your social relationships since you became unable to work:_____

Other

Do you have any problems remembering? __ YES__ NO If yes, please explain:_____

Do you have any problems concentrating? __ YES__ NO If yes, please explain:_____

Do you have any problems understanding? __ YES__ NO If yes, please explain:_____

Do have problems listening? __ YES __ NO If yes, please explain:_____

Do have problems getting along with others? __ YES__ NO If yes, please explain:_____

(Only complete the next section if you experience pain)

Part 8: INFORMATION ABOUT YOUR PAIN. Use Part 9: COMMENTS if more space is needed.

Describe your pain – Please include where the pain is located and if it spreads to other areas of your body._____

Describe the kind of pain (dull, burning, aching, sticking, sharp, shooting, etc) On a scale of 1-10 how severe is it. (10 is the worst)_

Describe how pain affects your activities, including your ability to concentrate and remember._____

How often do you experience pain? Is it constant or does it occur only with certain activities?_____

Is it worse in the morning, afternoon or evening?_____

How long does the pain last?

What makes your pain worse? (lifting, standing, cold weather, etc.)

Describe any treatments (medications, hot baths, therapy, exercise, etc.) used to relieve your pain. How well do they work? How often do you use them?

Describe the activities you have had to restrict or stop because of pain.

Part 9: COMMENTS

Use this space to provide additional information.

Applicant's Signature **Date** **Printed Name of Applicant**

FOR OFFICE USE ONLY

Comments by Case Manager: Please note any observations of the claimant's behavior, appearance, degree of limitations, etc.

Case Manager's Signature **Date** **Printed Name of Case Manager** **Case Manager's Phone #**

Supervisor's Signature **Date** **Printed Name of Supervisor** **Supervisor's Phone #**

_____Department of Social Services

MEDICAL REPORT FORM 402B

District: _____
Worker: _____
Phone#: _____
Date: _____
Client ID: _____

The information provided on this form may be used to determine eligibility for federal and state programs using Social Security disability criteria.

Please Print or Type

A. Patient Information:

Name of Patient: _____ Address: _____
Phone: _____ Date of Birth: _____ SSN# _____

Physician's Name: _____
Address: _____ Phone: _____

Specialty: _____
Dates of Examination _____ First Visit: _____ Last Visit: _____
Presenting Symptoms: _____

Height: _____ Weight: _____ BP: _____ Muscle Strength (1/5 to 5/5): UE _____ LE _____

B. Diagnosis: (You must attach progress notes or any other general records currently available)

_____ ICD-9-CM _____ Onset Date _____
_____ ICD-9-CM _____ Onset Date _____
_____ ICD-9-CM _____ Onset Date _____
_____ ICD-9-CM _____ Onset Date _____
_____ ICD-9-CM _____ Onset Date _____

HIV/AIDS INFECTION: Opportunistic and Indicator Disease (Please check all those that apply).

☐ Bacterial Infections ☐ HIV Wasting ☐ Viral Infections ☐ Diarrhea ☐ Protozoan or Helminthic Infections
☐ Neurological Abormalities ☐ Fungal Infections ☐ Other, specify _____
CD4 Count _____ Viral Load _____

Diagnostic Tests Performed: (To receive payment for laboratory tests or other diagnostic evaluations, including psychiatric and psychological evaluations, you must attach results or provide the date when results will be available.)

_____
_____
_____
_____

Treatment and Response: Include past treatment and response, if known, and current treatment and response. Please include therapy and recommendations:

_____
_____
_____
_____

C. MEDICATIONS: Include all prescription and nonprescription medications currently being taken, and side effects that may have implications for working, e.g. drowsiness and dizziness, etc.

Name of Medication	Reason For Medication	Side Effects

D. Referral to Specialist Recommended: Please explain reasons for referral_____

_____

_____

E. Physical Limitations:

In terms of the patient's ability to perform during an 8-hour workday with normal breaks, the patient can:

Activity	No Restrictions	Never	1 hr	2 hrs	3 hrs	4 hrs	5 hrs	6 hrs	7 hrs	8 hrs
Sit										
Stand										
Walk										
Climb										
Bend										
Squat										
Reach										
Crawl										

Check the **HEAVIEST** weight the patient can lift/carry.

□ Less than 10 lbs. □ 10 lbs. □ 20 lbs. □ 25 lbs. □ 50 lbs. □ 100 lbs. □ More than 100 lbs.

Check the weight the patient can lift/carry **FREQUENTLY**.

□ 10 lbs.□ 25 lbs.□ 50 lbs.□ More than 50 lbs.

The patient can be exposed to:

Environmental Conditions	Never	Occasionally	Frequently
Extreme Cold			
Extreme Heat			
Humidity			
Chemicals			
Dust			
Fumes/Odor			
Noise			
Height			

Describe how these environmental factors limit the patient's activities:_____

_____

_____

The patient can use hands for repetitive action such as:

Hand Action	Yes	No
Simple Grasping		
Pushing		
Fine Manipulation		

Visual Limitations: Visual Field: OD_____OS_____VA_____

(after corrections): OD_____OS_____VA_____

Hearing Limitations □ Yes □ No □ Minimal □ Moderate □ Extreme

Speaking Limitations □ Yes □ No □ Minimal □ Moderate □ Extreme

Is substance abuse present? □Yes □ No

Would the patient's current condition exist in the absence of substance abuse?
□ Yes □ No

F. Mental Status Information:

Does the patient suffer from mental illness? □ Yes □ No If yes, complete section F.
If no, go directly to section G.

Please provide all five axes of a DSM-IV diagnosis:

Axis I _____

Axis II _____

Axis III _____

Axis IV _____

Axis V GAF score: current _____ Highest level in the past year _____

Cognitive testing (list tests performed with results) VIQ _____ PIQ _____ FSIQ _____

Please check the appropriate degree of limitation for the following:

Degree of Limitation is defined as "None," "Mild," "Moderate," "Marked" and "Extreme."

Moderate refers to an impairment or combination of impairments that produce symptoms that have an impact on one's ability to function independently, appropriately and effectively on a sustained basis.

Marked refers to an impairment or combination of impairments that produce symptoms that seriously interfere with one's ability to function independently, appropriately and effectively on a sustained basis. **Extreme** is defined as continuous and severe.

FUNCTIONAL LIMITATIONS	DEGREE OF LIMITATION				
Restriction of activities of daily living	None □	Mild □	Moderate □	Marked □	Extreme □
Difficulties in maintaining social functioning	None □	Mild □	Moderate □	Marked □	Extreme □
Difficulties in maintaining concentration, persistence or pace	None □	Seldom □	Often □	Frequent □	Constant □
Episodes of decompensation, each of extended duration	None □	Once □	Repeated or Twice(three or more) □		Continual □

G. Evaluation of Medical Condition:

Based upon your evaluation is your patient's medical condition expected to last at least 12 months?

Yes ☐ No ☐

Please give date of onset and the length of time the patient's medical condition is expected to last or has lasted.

_____/_____/_____/ To _____/_____/_____/
month day year month day year

Is the patient's medical condition expected to result in death? Yes ☐ No ☐

Does the patient's medical condition prevent him or her from working in any employment?

Yes ☐ No ☐

If yes, please give the duration. _____/_____/_____/To____/_____/_____/
month day year month day year

H. Additional Comments:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Signature:_____ Print Name:_____

Title:_____ Telephone: _____

License:_____

MA Provider#:_____

Date:_____

DHR/FIA 402-B (Revised 3-07)