



WORK ACTIVITY REPORT - EMPLOYEE

ND DEPARTMENT OF HUMAN SERVICES

MEDICAL ASSISTANCE

SFN 1078 (Rev. 5/2005)

Send to: State Review Team
ND Department of Human Services
600 E Boulevard Ave, Dept. 325
Bismarck, ND 58505
Fax: (701) 328-1544

Note: This form has 8 pages.

IDENTIFICATION

Name of Claimant or Beneficiary	Blind Not Blind	Name of Wage Earner (If other than Claimant or Beneficiary)
Claimant or Beneficiary is Receiving:		
Social Security Disability Insurance (SSDI) Benefits		Both SSDI and SSI Disability Benefits
Supplemental Security Income (SSI) Disability Benefits		Neither SSDI or SSI Disability Benefits

PART I - TO BE COMPLETED BY THE DEPARTMENT OF HUMAN SERVICES

1.	Please use this form to describe your work activity since	Date (to be entered by SRT)
2.	We need to know this information to determine periods of actual work activity as opposed to periods of just employment (i.e. sick leave, vacation pay, etc.)	

ANSWER THE QUESTIONS ON THIS FORM AND RETURN IT AND ANY OTHER INFORMATION ABOUT YOUR CLAIM TO THE STATE REVIEW TEAM AT THE ADDRESS LISTED IN THE UPPER RIGHT HAND CORNER OF THIS FORM.

PART II - TO BE COMPLETED BY PERSONS APPLYING FOR OR RECEIVING BENEFITS

You should answer each of the questions below as best and with as many details as you can. This information will help up decide if you should get or keep getting benefits. For any question below, if you need more space, use item 9, on pages 5 and 6. Remember to write the number of the question that you are answering in item 9.

1.	<p>HAVE YOU WORKED SINCE THE DATE SHOWN IN ITEM 1 OF PART 1, ABOVE?</p> <p>YES If you did work, go to item 3 and answer the rest of the questions and sign and date the form.</p> <p>NO If you did not work, but earnings were reported for you as shown in item 2 of Part I above, go to item 2 below.</p>
2.	<p>REPORT WORK OR EARNINGS</p> <p>If you did not work, but earnings were reported for you as shown in item 2 of Part 1, explain what the pay was for.</p> <p>For example, sometimes pay is sick pay, vacation pay or holiday pay that you earned, or for work that you did before becoming unable to work because of your condition.</p> <p>If you can't explain the earnings reported for you or you don't remember what the total earnings are for, ask your employer(s).</p> <p>Explanation of Earnings</p> <p>If you need more space, use Item 9. Then go to Items 8 and 10.</p>

3.

TELL US ABOUT YOUR WORK SINCE THE DATE IN ITEM 1 OF PART 1 ABOVE.

(If you are not sure about some things, ask your employer to help you. If you need more space, use item 9, on Pages 5 and 6. Remember to write the number of the question that you are answering in Item 9.)

A.

Employer's Address (Include street, city, state and zip code)

Date Work Started

Date Work Ended

Starting Hourly Pay

Current or Ending Pay

Number of Hours Worked (on average)

PER DAY

PER WEEK

Supervisor's Name

Supervisor's Telephone Number
(Include area code)

Check each block below that is true for this work:

I stopped working within 6 months, or I reduced my work hours and earnings within 6 months, or within 6 months I had to change the type of work I was doing (i.e. You were a plumber and changed to lighter work.) because

of my medical condition.

special conditions at work related to my medical condition that allowed me to work were removed.

I stopped working or changed the type of work I was doing for other reasons. (Tell us what the other reasons were below.)

B.

Employer's Address (Include street, city, state and zip code)

Date Work Started

Date Work Ended

Starting Hourly Pay

Current or Ending Pay

Number of Hours Worked (on average)

PER DAY

PER WEEK

Supervisor's Name

Supervisor's Telephone Number
(Include area code)

Check each block below that is true for this work:

I stopped working within 6 months, or I reduced my work hours and earnings within 6 months, or within 6 months I had to change the type of work I was doing (i.e. You were a plumber and changed to lighter work.) because

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C.

Employer's Address (Include street, city, state and zip code)

Date Work Started	Date Work Ended	Starting Hourly Pay	Current or Ending Pay
Number of Hours Worked (on average)		Supervisor's Name	Supervisor's Telephone Number (Include area code)
PER DAY PER WEEK			

Check each block below that is true for this work:

I stopped working within 6 months, or I reduced my work hours and earnings within 6 months, or within 6 months I had to change the type of work I was doing (i.e. You were a plumber and changed to lighter work.) because

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special conditions at work related to my medical condition that allowed me to work were removed.

I stopped working or changed the type of work I was doing for other reasons. (Tell us what the other reasons were below.)

D.

Employer's Address (Include street, city, state and zip code)

Date Work Started	Date Work Ended	Starting Hourly Pay	Current or Ending Pay
Number of Hours Worked (on average)		Supervisor's Name	Supervisor's Telephone Number (Include area code)
PER DAY PER WEEK			

Check each block below that is true for this work:

I stopped working within 6 months, or I reduced my work hours and earnings within 6 months, or within 6 months I had to change the type of work I was doing (i.e. You were a plumber and changed to lighter work.) because

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I stopped working or changed the type of work I was doing for other reasons. (Tell us what the other reasons were below.)

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TELL US ABOUT YOUR WORK SINCE THE DATE IN ITEM 1 OF PART 1 ABOVE.

(If you are not sure about some things, ask your employer to help you. If you need more space, use item 9, on Pages 5 and 6. Remember to write the number of the question that you are answering in Item 9.)

E.

Employer's Address (Include street, city, state and zip code)

Date Work Started

Date Work Ended

Starting Hourly Pay

Current or Ending Pay

Number of Hours Worked (on average)

PER DAY

PER WEEK

Supervisor's Name

Supervisor's Telephone Number
(Include area code)

Check each block below that is true for this work:

I stopped working within 6 months, or I reduced my work hours and earnings within 6 months, or within 6 months I had to change the type of work I was doing (i.e. You were a plumber and changed to lighter work.) because

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I stopped working or changed the type of work I was doing for other reasons. (Tell us what the other reasons were below.)

F.

Employer's Address (Include street, city, state and zip code)

Date Work Started

Date Work Ended

Starting Hourly Pay

Current or Ending Pay

Number of Hours Worked (on average)

PER DAY

PER WEEK

Supervisor's Name

Supervisor's Telephone Number
(Include area code)

Check each block below that is true for this work:

I stopped working within 6 months, or I reduced my work hours and earnings within 6 months, or within 6 months I had to change the type of work I was doing (i.e. You were a plumber and changed to lighter work.) because

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(If you are not sure about some things, ask your employer to help you. If you need more space, use item 9, on Pages 5 and 6. Remember to write the number of the question that you are answering in Item 9.)

G.

Employer's Address (Include street, city, state and zip code)

Date Work Started	Date Work Ended	Starting Hourly Pay	Current or Ending Pay
Number of Hours Worked (on average)		Supervisor's Name	Supervisor's Telephone Number (Include area code)
PER DAY PER WEEK			

Check each block below that is true for this work:

I stopped working within 6 months, or I reduced my work hours and earnings within 6 months, or within 6 months I had to change the type of work I was doing (i.e. You were a plumber and changed to lighter work.) because

of my medical condition.

special conditions at work related to my medical condition that allowed me to work were removed.

I stopped working or changed the type of work I was doing for other reasons. (Tell us what the other reasons were below.)

4.

Since the date you started working on or after the date shown in item 1 of Part 1, above, have there been any months during which you earned over \$200 per month through 12/2000 or over \$530 beginning 01/2001 (before anything was withheld; e.g., taxes)?

No (Go to Item 5.)

Yes (Tell us which month and year and the amount you earned that month in the chart below. If you need more space, use Item 9, on pages 5 and 6. Remember to write the number of the question that you are answering in Item 9.)

MONTH/YEAR	AMOUNT	MONTH/YEAR	AMOUNT	MONTH/YEAR	AMOUNT
	\$		\$		\$
	\$		\$		\$
	\$		\$		\$
	\$		\$		\$

5.

SPECIAL WORK CONDITIONS - Do (Did) you get special help on-the-job or extra pay in any of the jobs that you told us about in Item 3?

NO (Go to Item 6.)

YES Check all of the boxes that are true for you and tell us for which job(s) you received that help and tell us about any other special condition(s) or help that you got on a job.

I needed and got special help from other workers in doing my job.

I was given a job based on my past services to an employer.

I was given special equipment or was given work that was suited to my condition.

I worked irregular hours or took frequent rest periods.

I was allowed to work at a lower standard of productivity.

I worked in a sheltered work center.

I worked for a relative or friend.

I was hired through a special program for training or therapy (e.g., vocational rehabilitation, supported employment.)

5.

SPECIAL WORK CONDITIONS - Continued

Check all of the boxes that are true for you and tell us for which job(s) you received that help and tell us about any other special condition(s) or help that you got on a job.

My job duties were different than other workers' job duties doing the same work because:

I worked fewer hours.

I got different pay.

I had different duties; fewer or easier duties.

I had extra help, extra supervision, or a job coach.

I was given special transportation to and from work.

I got special help getting ready for work.

I was paid extra rest periods at work or extra time off from work and other workers were not.

Other special help. (Explain below.)

In the spce below, tell us for which job(s) you received the special help. If you need more space, use Item 9.

6.

OTHER/SPECIAL PAYMENTS- Do (Did) you get any payment(s) from an employer in addition to regular pay? For example, did you get any tips, bonuses, sick or disability pay, vacation pay, meals, room or rent, transportation or use of a car or vehicle, or childcare?

No (Go to Item 7.)

Yes Tell us below what these payments were. If you need more space, use Item 9.

EMPLOYER	TYPE OF PAYMENT	AMOUNT OR ESTIMATE OF THE DOLLAR VALUE	MONTH & YEAR
		\$	
		\$	
		\$	
		\$	
		\$	

7.

SPECIAL WORK EXPENSES (IMPAIRMENT-RELATEDWORK EXPENSES) - Do (Did) you spend any money of your own earnings for any things or services related to your condition that allowed you to work and for which you did not get paid back?

For example, medicines, bandages, braces, wheelchair, artificial arm or leg, brialle equipment, special telephone or computer equipment, modifications to home (wider doreways, roll-in shower, ramps, wheelchair-lift), or modifications to a car (automatic wheelchair-lift), personal assistance (personal care attendant.)

No Go to Item 8.

Yes Tell us below about the bills, or part of the bills, that you paid for things or services related to your medical condition that you needed in order to work. (Upon review, you may be required to provide proof of these expenses.) Do not show any bills or amounts paid by an insurance company or any other organization or person or paid to you by an insurance company or other organization or person. (Example: An insurance company might pay all or part of the bill at a later time.)

7.	SPECIAL WORK EXPENSES (IMPAIRMENT-RELATED WORK EXPENSES) - Continued		
	ITEM OR SERVICE	COST	DATE(S) PAID (MONTH & YEAR)
		\$	
		\$	
		\$	
		\$	
		\$	
		\$	
	SPECIAL TRANSPORTATION	COST	DATE(S) PAID (MONTH & YEAR)
	MODIFIED VEHICLE	\$	
	TAXI-TYPE SERVICE	\$	

8.	<p>VOCATIONAL REHABILITATION - Are (Were) you getting any help from a vocational rehabilitation or employment services provider to get the services and/or training you need to get ready to start working, find work or keep working?</p> <p style="text-align: center;"> <input type="checkbox"/> No If you answered no, would you like to get these services? <input type="checkbox"/> Yes <input type="checkbox"/> No (Go to Item 10.) </p> <p style="text-align: center;"> <input type="checkbox"/> Yes Tell us the name and address of the people who are (were) giving you vocational rehabilitation or employment services and training. </p>	
	Vocational Rehabilitation/Employment Services Provider	
	Name	Address (Include street, city, state & zip)
	Counselor's Name	Counselor's Telephone Number (Include area code)
	If you need more space, go to Item 9, below.	

9.	<p>More Space. For any question above, if you need more space, use the space below. Remember to write the number of the question that you are answering before you begin.</p> <div style="height: 300px; border: 1px solid black;"></div>
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9.

More Space - (Continued) For any question above, if you need more space, use the space below. Remember to write the number of the question that you are answering before you begin.

10.

I authorize any employer, agency or other organization to disclose to the State agency who may determine or review my entitlement to disability benefits any information about my medical condition or my work.

SIGN AND DATE THIS FORM

I certify under penalty of law that the information on this form is true.

Signature of Claimant, Beneficiary or Representative

Date

Address (Include street, city, state and zip code)

Telephone Number

Witness must sign ONLY if this statement is signed by mark (i.e., X) above. If signed by mark (X), two witnesses to the signing who know the person making the statement must sign below, giving their full addresses and telephone numbers.

1. Signature of Witness

2. Signature of Witness

Address (Include street, city, state and zip code)

Address (Include street, city, state and zip code)

Telephone Number

Telephone Number