ATTACHMENT VI

TRANSMITTAL SHEET

FOR MEDICAID BUY-IN- WORKING PERSONS WITH DISABILITIES PROGRAM

NEW YORK STATE DEPARTMENT OF HEALTH

SUBMITTING AGENCY

DATE SENT

Please attach for each case: The completed LDSS-1151 - "Disability Interview;" copies of all "Request for Information" forms sent to medical providers; copies of all "Consent for Release of Medical Information" forms signed by the applicant; and copies of any medical information received to date.

Submit three **(3)** copies of each transmittal sheet.

FOR AGENCY COMPLETION		**REVIEW TEAM DETERMINATIONS**			
Name of Client (Surname, First Name)	Case Number	Disability Type	Case Type	Decision	Effective Date Of Disability

KEY:

Disability Type
MI – Mental Impairment
PI – Physical Impairment
MI/PI - Combination of Both

Case Type
N – New
CDR – Continuing Disability Review

Decision
I – Group I
II – Group II
DIS – Disapproved
NA – No Action

SIGNATURE (For Agency)	TITLE	TELEPHONE NO.