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: