**Attachment III**

INSERT DISTRICT LETTERHEAD HERE

Medical provider/facility
Address

Date:_________________________

Re: (Name of client)

Date of Birth:__________________

Dear _______________________________:

Enclosed find a release for medical information concerning the above noted individual. This individual has applied for Medicaid benefits in the disabled category. In many cases, Medicaid eligibility is dependent on a determination of disability.

Medical evidence forms the foundation for determination of disability. It must allow a determination of the severity and duration of an impairment and the extent of limitation imposed for the time period in question.

Please note that individuals who have been previously approved for disability must be reviewed periodically in order to continue to be eligible for disability benefits.

**The medical evidence checked below is requested at this time:**

____ Copy of medical records (e.g., progress notes, consultation reports, diagnostic test reports) for the following year(s): ___________________________
____ Hospital records for the following year(s) ____________________
____ LDSS-486T form, signed or co-signed by a physician (**Adult cases only**)
____ Childhood Medical Disability Report (OHIP form 0005), signed by physician
____ Questionnaire of School Performance (OHIP form 0006), completed by teacher, along with current IEP report
____ Description of Child's Activities (OHIP form 0007), completed by parent/guardian

Please submit requested medical evidence to the above noted address.

If you have not seen this individual in the timeframe noted above, please check the line below, and sign and return this letter to the above noted address.
_____ No medical records exist for this individual for the timeframe noted above.

_________________________________________
(Signature)

Thank you for your cooperation.

Signed/Title _____________________________________Telephone number:________________

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