MEDICAL HISTORY AND DISABILITY STATEMENT

Instructions: It is very important that you read and answer all questions carefully. Your responses may help to determine if you are disabled. You may ask someone such as a relative, friend, eligibility worker, or someone from the health care field to help you complete this form. If someone helps you to complete the form, the answers should, to the extent possible, be in your own words.

Name of potentially disabled individual: _____
Last Name First Name

Beneficiary ID Number:_____Case Number: _____

SOCIAL SECURITY DISABILITY INSURANCE (SSDI) INFORMATION

1. Are you receiving SSDI? [ ] Yes [ ] No
2. Have you ever received SSDI? [ ] Yes [ ] No
3. If yes to #2, why did the SSDI stop? _____

_____

4. Have you applied for social security benefits for your current disability? Check appropriate block(s):
   [ ] No
   [ ] Yes. Date applied for benefits: _____
   [ ] My application is pending.
   [ ] My application has been approved and I am currently or will soon be receiving benefits.
   [ ] My application was denied. Explain reason given for denial of benefits:

_____

_____

MEDICAL PROFILE

1. Describe your disability and explain the reason(s) why you are unable to work:

_____

_____

2. Describe the cause of your disability (i.e. accident, injury, illness, etc):

_____

_____

3. Describe all treatment(s) prescribed by any physician for your disability:

_____

_____

4. How often do you see your doctor for treatment? (Check one of the following blocks)
   [ ] weekly [ ] several times a month [ ] monthly [ ] quarterly or more

5. List hospitalization(s) within the past two years, reason for hospitalization(s), and duration(s) of stay:

_____

_____

_____

EDUCATION LEVEL

1. Are you able to understand and communicate in English: [ ] Yes [ ] No

2. Education: Circle the last grade you completed

   1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

3. List any educational Degree, Diploma, Training, or Certificate received:

   _____

   _____

PREVIOUS WORK EXPERIENCE

1. Have you ever been employed? [ ] Yes [ ] No
   If yes, list the last job and type of work: _____

   _____

   _____

   _____

2. List the date of your last employment and reason(s) why your job was terminated:

   _____

   _____

****

Check "A" or "B" below and sign. Also, read and initial to acknowledge "C". (Must be completed or form will not be accepted)

A. _____I certify that the information I have provided to be true, accurate, and correct to the best of my knowledge.

B. _____I choose not to complete this form.

Read and initial:

C. _____I understand that if I am found to have a disability for one year or more, the Department of Human Services will look at my assets to determine if I am still Medicaid eligible. If I go over my asset limit, I may lose my Medicaid eligibility.

_____ _____
Signature of Applicant/Beneficiary Date

_____ _____ _____
Signature of Person Applying for Applicant/Beneficiary Relationship Date

If applicant/beneficiary did not complete this form on their own, explain the reason(s) why: _____

_____

_____

_____ _____
Name Of Person Who Assisted To Complete Form Date

MQD Remarks:

_____

_____

_____

_____