NON–MEDICAL EVALUATION OF DISABILITY

Initial ☐ Review ☐ Family Services Specialist: _____

Application Date: _____

TDD Access: Relay NH 1-800-735-2964 District Office: _____

PERSONAL INFORMATION:

Name: _____ Male ☐ Female ☐ Date of Birth: _____

List any other names that you may have used on your medical records, such as maiden name, previous married name, etc.

_____

Are you currently receiving NH Medicaid? Yes ☐ No ☐

Household Residence Address

Street Address: _____

City/Town: _____ Zip Code: _____

Household Mailing Address

Street / PO Box Address: _____

City/Town: _____ Zip Code: _____

Daytime Telephone Number:

(If you have no phone number where you can be reached, give us a daytime number where we can leave a message.)

( ) _____ Your Number ☐ Message Number ☐ None ☐
Area Code Number

Can you **speak and understand English**? Yes ☐ No ☐

If "NO", what is your preferred language? _____

If you cannot speak and understand English, is there someone we may contact who speaks and understands English and will give you messages?
Yes ☐ No ☐
(If "YES," complete the following information)

_____ Name _____ Relationship _____ Daytime Phone

Can you **read and understand English**? Yes ☐ No ☐

Can you **write more than your name in English**? Yes ☐ No ☐

Social Security Number: _____

Have you applied for Social Security Disability Benefits? Yes ☐ No ☐

If "YES," to above statement is your application:
☐ Pending
☐ Approved
☐ Denied

If you are receiving SSDI/SSI benefits, specify when the benefits started: _____ Month _____ Year

ABILITY TO WORK:

What are the **illnesses, injuries or conditions** that limit your ability to work? _____

_____

_____

Do your illnesses, injuries or conditions cause you **pain**? Yes ☐ No ☐

Do your illnesses, injuries or conditions cause you to: (check all that apply and explain below)

- ☐ Work fewer hours
- ☐ Change your job duties
- ☐ Make job-related changes such as attendance, help needed, or employers?

_____

_____

Are you working now? Yes ☐ No ☐ If "**NO**," when did you stop working? _____
Month Day Year

Why did you stop working?

_____

_____

_____

VOCATIONAL REHABILITATION:

Are you receiving vocational rehabilitation services? Yes ☐ No ☐

Have you received these services in the past? Yes ☐ No ☐

When? _____

Where? (name of the agency): _____

City/town where you received vocational rehabilitation services: _____

Counselor's name: _____

Counselor's office address: _____

_____

Counselor's telephone number: _____

EDUCATION: Check the highest grade of **school** completed.

Grade School:								High School					College			
1	2	3	4	5	6	7	8	9	10	11	12	GED	1	2	3	4 OR MORE
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Did you attend **special education** classes? Yes ☐ No ☐

Have you completed any type of **special job training, trade or vocational school**? Yes ☐ No ☐

If "YES," what type? _____ Approximate date completed: _____

EMPLOYMENT:

List all of the jobs that you have had in the 15 years prior to applying for Medicaid disability.

Job Title **(Example, Cashier)**	**Type of Business** (Example, Department Store)	**Dates Worked**		**Hours worked each day**	**# of Days worked each week**	**Rate of Pay**
		From (month & year)	**To** (month & year)			(Per hour)
						$
						$
						$
						$
						$
						$
						$
						$
						$

Which job listed above did you do the **longest**? Job Title: _____

In this job, did you:
Use machines, tools or equipment? Yes (explain below) ☐ NO ☐
Use technical knowledge or skills? Yes (explain below) ☐ NO ☐
Write reports or complete forms? Yes (explain below) ☐ NO ☐

Describe this job. What did you do all day? (If you need more space, write on the back of this sheet.)
_____

In this job, how many **TOTAL** hours each **day** did you:

Walk? _____ Sit? _____ Stoop? _____ Crouch? _____ Grab or Grasp? _____

Stand? _____ Climb? _____ Kneel? _____ Crawl? _____ Write or Type? _____

Lifting & Carrying (Explain what you lifted, how far you carried it, and how often you did this.)
_____
_____

Did you supervise other people in this job? Yes ☐ No ☐

Do (Did) you get special help on-the job? Yes ☐ No ☐ .

If **Yes** (Check all the boxes below that are true)

☐ I needed & got help from other workers to do my job
☐ I worked with a friend or relative
☐ I worked through a special program such as Vocational Rehab. or supported employment
☐ Other: (specify) _____

If "**YES**," tell us which jobs you received extra help
_____
_____
_____
_____
_____

MENTAL HEALTH INFORMATION:

Do you feel you have an emotional/mental health problem? Yes ☐ No ☐

If **Yes**, please explain:

_____

_____

_____

_____

Are you receiving services from a mental health agency/psychologist/psychologist: Yes ☐ No ☐

Do you have a case manager? Yes ☐ No ☐

Name of case manager: _____ Telephone #: _____

Are you involved with an Area Agency or other Private Agency? Yes ☐ No ☐

Name of Agency:

_____

Agency address: _____

_____

INSURANCE AND INJURY LIABILITY INFORMATION

Do you have other medical insurance? Yes ☐ No ☐

Insurance Company: _____

Was your disability the result of an accident? Yes ☐ No ☐

Type of accident – please explain:

_____

_____

Date of accident: _____

Was the accident **employment related**? Yes ☐ No ☐

Name and address of your employer at the time of the accident: _____

_____

Did you file for Worker's Compensation benefits? ☐ Yes ☐ No

If "Yes" were they approved? ☐ Yes ☐ No

Tell us who may have medical records or other information about your illnesses, injuries or conditions.

List each DOCTOR/THERAPIST/OTHER INDIVIDUAL that will have medical information about you.
DO NOT LIST HOSPITALS, CLINICS OR MEDICAL CENTERS HERE.

NAME			Date of First Visit
STREET ADDRESS			
CITY	STATE	ZIP	Date of Last Visit
PHONE Area Code ( ) Phone Number			
Reason(s) for visit			

NAME			Date of First Visit
STREET ADDRESS			
CITY	STATE	ZIP	Date of Last Visit
PHONE Area Code Phone Number			
Reason(s) for visit			

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STREET ADDRESS			
CITY	STATE	ZIP	Date of Last Visit
PHONE Area Code ( ) Phone Number			
Reason(s) for visit			

List each HOSPITAL/CLINIC/MEDICAL CENTER that will have medical records or other information about your illnesses, injuries or conditions.

HOSPITAL/CLINIC/MEDICAL CENTER			☐ Inpatient Stays Dates:	☐ Outpatient Visits ☐ Emergency Room Dates:
STREET ADDRESS				
CITY	STATE	ZIP		
PHONE Area Code ( ) Phone Number				
What doctors do you see at this hospital/clinic/medical center on a regular basis?				
Reason(s) for visits:				

HOSPITAL/CLINIC/MEDICAL CENTER			☐ Inpatient Stays Dates:	☐ Outpatient Visits ☐ Emergency Room Dates:
STREET ADDRESS				
CITY	STATE	ZIP		
PHONE Area Code ( ) Phone Number				
What doctors do you see at this hospital/clinic/medical center on a regular basis?				
Reason(s) for visits:				

HOSPITAL/CLINIC/MEDICAL CENTER			☐ Inpatient Stays Dates:	☐ Outpatient Visits ☐ Emergency Room Dates:
STREET ADDRESS				
CITY	STATE	ZIP		
PHONE Area Code ( ) Phone Number				
What doctors do you see at this hospital/clinic/medical center on a regular basis?				
Reason(s) for visits:				

HOSPITAL/CLINIC/MEDICAL CENTER			☐ Inpatient Stays Dates:	☐ Outpatient Visits ☐ Emergency Room Dates:
STREET ADDRESS				
CITY	STATE	ZIP		
PHONE Area Code ( ) Phone Number				
What doctors do you see at this hospital/clinic/medical center on a regular basis?				
Reason(s) for visits:				

Do you **currently take any medication** for your illnesses, injuries or conditions? Yes ☐ No ☐
Have you sought financial help with getting your medications? Yes ☐ No ☐
If "**YES**," tell us the following information: (If needed, look at your medicine bottles)

Name of Medicine	Doctor who ordered the medication	Reason for Medication

Fill in the information below if you have **had, or are scheduled for**, any of the following medical tests.

Type of Test	Date test was done or date test will be done	Name of place the test was done
EKG (Heart Test)		
Biopsy—Name of Body part		
Hearing Test		
Vision Test		
Psychiatric Evaluation		
IQ Testing		
Breathing Tests		
X-Ray—Name of body part(s)		
MRI—Name of body part(s)		
CT Scan—Name of body part(s)		

The information on this form will be used to determine whether your condition impairs your ability to perform work or services and to establish the duration of your disability. It is important that you have answered every question. The information you give us on this form, in combination with medical information that we get from your doctors and therapists, will determine if you meet the medical criteria for the NH Medicaid program you requested. Please submit any medical records you have with this application.

Please add any additional comments that you think would help us in making a decision regarding your disability:

_____

_____

_____

_____

_____

_____

_____

(USE EXTRA PAPER IF NEEDED)

I hereby certify that I understand all statements made, and that the information given on this form is true and complete to the best of my knowledge. I also understand that if I deliberately give false information or withhold information related to my situation, now or in the future, I am liable for prosecution for fraud.

_____ _____
Signature of Applicant Date

☐ I completed this form by myself ☐ I had help completing this form

_____ _____
Signature of person who helped complete this form Date

_____
Relationship to applicant

ALL QUESTIONS MUST BE ANSWERED. AN INCOMPLETE FORM WILL NOT BE ACCEPTED.