NEW YORK STATE DEPARTMENT OF HEALTH
State Disability Review Unit

Disability Questionnaire

COMPLETED BY THE STATE DISABILITY REVIEW UNIT:

NAME:

First: _____

Middle: _____

Last: _____

Social Security Number (last 4 digits): _____

Date of Birth: _____

Telephone No: _____

Case Number: _____

Client ID Number (CIN): _____

Disability ID Number (DIN): _____

Medicaid application date: _____

Medicaid Waiver? ☐ Yes ☐ 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:	Phone Number:	Address:
Reason for seeing:		
Name:	Phone Number:	Address:
Reason for seeing:		
Name:	Phone Number:	Address:
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.)

Name:	Address:
Reason:	
Name:	Address:
Reason:	
Name:	Address:
Reason:	

D. Have you received services from any agencies to assist you with your impairment(s) within the past 12 months? ☐ Yes ☐ No
(If "Yes", please complete the section below.)

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:	
Name:	Address:
Reason:	
Name:	Address:
Reason:	

PART III – INFORMATION ABOUT YOUR EDUCATION AND LITERACY

If a disability determination cannot be made based on your medical conditions alone, the factors of education, literacy, and work history will be used to determine disability.

A. **What is the highest grade level of schooling that you have completed?** _____

B. If you have a child up to the age of 21 attending school or a vocational program, please provide the school or program's name and address.

School/Program Name: _____

Address: _____

_____

Please complete the DOH-5173, Authorization for Release of Medical Information Pursuant to HIPAA form for this school/program.

C. Were (are) you involved in Special Education classes in school? ☐ Yes ☐ No

D. Did (do) you receive any special help or accommodations in school? ☐ Yes ☐ No *(If "Yes", please describe.)*

(If you have a copy of your IEP, please include it with the returned forms.)

E. Have you received any vocational training or additional education within the past 12 months? ☐ Yes ☐ No
(If "Yes", please describe.)

F. Can you read a simple message in any language (such as simple instructions, or a list of items)? ☐ Yes ☐ No

G. Can you write a simple message in any language? ☐ Yes ☐ No

H. Was assistance or an interpreter necessary to complete this application? ☐ Yes ☐ No
(If "Yes", please indicate your primary language.)

PART IV – INFORMATION ABOUT WORK YOU DID IN THE PAST 15 YEARS

Have you worked in the past 15 years? ☐ Yes ☐ No

If YES, 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.

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 IV

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PART IV – INFORMATION ABOUT WORK YOU DID IN THE PAST 15 YEARS

CONTINUED

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:		

Name of Person Completing Form (Please Print):	**Date:**
Telephone Number:	