Iowa Department of Human Services

Disability Report for Adults

READ ALL OF THIS INFORMATION BEFORE YOU BEGIN COMPLETING THIS FORM.

IF YOU NEED HELP

If you need help with this form, complete as much of it as you can, and ask your income maintenance worker to help you finish it.

HOW TO COMPLETE THIS FORM

The information that you give us on this form will be used by the office that makes the disability decision on your disability claim. You can help them by completing as much of the form as you can.

- Fill out as much of this form as you can then ask your income maintenance worker for help.
- Print or type.
- **Do not leave answers blank.** If you do not know the answers, or the answer is **none** or **does not apply**, please write:
  - Don't know.
  - None.
  - Does not apply.
- **In Section 4, put information on only one doctor/hospital/clinic in each space**.
- Each address should include a ZIP code. Each telephone number should include an area code.
- **Do not ask a doctor or hospital to complete the form.** However, you can get help from other people, like a friend or family member.
- When a question refers to **you**, **your** or **disabled person**, it refers to the person who is applying for help to pay medical bills. If you are filling out the form for someone else, please provide information about him or her.
- Be sure to explain an answer if the question asks for an explanation, or if you want to give additional information.
- If you need more space to answer any questions or want to tell us more about an answer, please use the **Remarks** section on page 9, and show the number of the question being answered.

ABOUT YOUR MEDICAL REPORTS

If you have any medical records and copies of prescriptions at home for the person who is applying for help, send them with your completed forms or bring them with you to your interview. Also, bring in a list of any prescriptions with you. If you need the records back, tell us and we will photocopy them and return them to you.

You do not need to ask doctors or hospitals for any medical records that you do not already have. With your permission, we will do that for you. The information we ask for on this form tells us to whom we should send a request for medical and other records. If you cannot remember the names and addresses of any of the doctors or hospitals, or the dates of treatment, try to get this information from the telephone book, or from medical bills, prescriptions and prescription bottles.

Please remove this sheet before returning the completed form.

Iowa Department of Human Services

Disability Report for Adults

Section 1. Information About the Disabled Person

PLEASE PRINT, TYPE, OR WRITE CLEARLY AND ANSWER ALL ITEMS TO THE BEST OF YOUR ABILITY. If you are helping someone else, enter his or her name and social security number in the space provided and answer all questions. COMPLETE ANSWERS WILL HELP PROCESS THE APPLICATION FASTER.

A. Name (First, Middle Initial, Last)	B. Social Security Number

C. **Daytime Telephone Number** (If you have no number where you can be reached, give us a **daytime** number where we can leave a message for you.)

Telephone Number ( )	❑ Your Number ❑ Message Number ❑ None

D. Give the name of a **friend or relative** that we can contact (other than your doctors) **who knows about your illnesses, injuries, or conditions** and can help you with your claim.

Name	Relationship	Daytime Phone ( )	
Address	City	State	Zip Code

E. What is your **height** without shoes? (feet inches) _____.

F. What is your **weight** without shoes? (pounds) _____.

G. Do you have a medical assistance card? (for example Medicaid) ❑ Yes ❑ No If yes, show number here _____

H. Can you speak and understand English? ❑ Yes ❑ No
If **no**, what languages can you speak? _____

If you cannot **speak English**, give us the name of someone we may contact who speaks English and will give you messages. (If this is the same person as in "D" above, show **same** here.)

Name	Relationship	Daytime Phone ( )	
Address	City	State	Zip Code

I. Can you **read English**? ❑ Yes ❑ No Can you **write more than your name in English**? ❑ Yes ❑ No

Section 2. Your Illnesses, Injuries or Conditions and How They Affect You

A. What are the illnesses, injuries, or conditions that limit your ability to work?

B. How do your illnesses, injuries, or conditions limit your ability to work?

C. Do your illnesses, injuries, or conditions cause you **pain**? ❑ Yes ❑ No

D. When did your illness, injuries, or conditions **first bother you**?

Month	Day	Year

E. Have you **ever worked**? ❑ Yes ❑ No (If **no**, go to Section 4.)

F. Are you **working now**? ❑ Yes ❑ No
If **no**, when did you **stop working**?

Month	Day	Year

G. Why did you **stop working**?

H. Did you **work at any time** after the date your illness, injuries, or conditions first bothered you? ❑ Yes ❑ No

I. If **yes**, did your illness, injuries, or conditions cause you to (check all that apply):

- ❑ **Work fewer hours?** (Explain below)
- ❑ **Change your job duties?** (Explain below)
- ❑ **Make any job-related changes such as your attendance, help needed, or employers? (**Explain below)

Section 3. Information About Your Work

A. List the **jobs** that you have had in the **last 15 years that you worked**.

Job Title (Example: Cook)	Type of Business (Example: Restaurant)	Dates Worked (Month & Year)		Hours Per Day	Days Per Week	Rate of Pay (Per hour, day, week, month or year)	
		From	To				
						$	
						$	
						$	
						$	
						$	
						$	
						$	

Name and address of your most current employer or most recent employer: _____

_____

B. Describe the **job above** that you did the **longest**. (What did you do all day in this job?) _____

_____

_____

C. In **this job** did you:

Use machines, tools, or equipment? ❑ Yes ❑ No

Use technical knowledge or skills? ❑ Yes ❑ No

Do any writing, complete reports, or perform any duties like this? ❑ Yes ❑ No

Did you supervise other people? ❑ Yes ❑ No

If **yes**, was this your main duty? _____

D. In this job, how many total hours each day did you:

Walk _____ Stoop (bend down and forward at waist) _____

Stand _____ Kneel (bend legs to rest on knees) _____

Sit _____ Crouch (bend legs & back down & forward) _____

Climb _____ Crawl (move on hands and knees) _____

Handle (grab or grasp big objects) _____

Write (type or handle small objects) _____

E. Lifting and carrying (Explain what you lifted, how far you carried it, and how often you did this)

_____

_____

F. Check **heaviest** weight lifted:

❑ Less than 10 lbs ❑ 10 lbs ❑ 20 lbs ❑ 50 lbs ❑ 100 lbs or more ❑ Other _____

G. Check weight **frequently** lifted: (By frequently we mean from 1/3 to 2/3 of the workday.)

❑ Less than 10 lbs ❑ 10 lbs ❑ 25 lbs ❑ 50 lbs or more ❑ Other _____

Section 4. Information About Your Medical Records

A. Have you been seen by a doctor/hospital/clinic or anyone else for the illnesses, injuries, or conditions that limit your ability to work? ❑ Yes ❑ No

B. Have you been seen by a doctor/hospital/clinic or anyone else for emotional or mental problems that limit your ability to work? ❑ Yes ❑ No

If you answered "NO" to both of these questions, go to Section 5.

C. List **other names** you have used on your medical records _____

_____

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

DOCTOR/HMO/THERAPIST

D. List each **doctor/HMO/therapist**. Include your **next appointment**.

1.

Name			**DATES**
Street Address			**First Visit**
City	State	Zip	**Last Seen**
Phone ( )	Chart/HMO No.		**Next Appointment**
Reasons for visits			
What **treatment** was received?			

2.

Name			**DATES**
Street Address			**First Visit**
City	State	Zip	**Last Seen**
Phone ( )	Chart/HMO No.		**Next Appointment**
Reasons for visits			
What **treatment** was received?			

DOCTOR/HMO/THERAPIST (Cont.)

3.

Name			DATES
Street Address			**First Visit**
City	State	Zip	**Last Seen**
Phone ( )	Chart/HMO No.		**Next Appointment**
Reasons for visits			
What **treatment** was received?			

If you need more space, use Remarks, Section 9, on Page 9.

HOSPITAL/CLINIC

E. List each **hospital/clinic**. Include your **next appointment**.

1.

HOSPITAL/CLINIC			TYPE OF VISIT	DATES	
				Date In	**Date Out**
Name			❑ **Inpatient stays** (stayed at least overnight)		
Street Address					
				Date First Visit	**Date Last Visit**
City	State	Zip Code	❑ **Outpatient stays** (sent home same day)		
Phone ( )			❑ **Emergency Room Visits**	**Date of Visits**	

Next appointment _____ Your hospital/clinic **number** _____

Reason for visits _____

_____

What **treatment** did you receive? _____

_____

What **doctors** do you see at this hospital/clinic on a regular basis? _____

_____

HOSPITAL/CLINIC (Cont.)

2.

HOSPITAL/CLINIC			TYPE OF VISIT	DATES	
				Date In	Date Out
Name			❑ **Inpatient stays** (stayed at least overnight)		
Street Address					
				Date First Visit	Date Last Visit
City	State	Zip Code	❑ **Outpatient stays** (sent home same day)		
Phone ( )			❑ **Emergency Room Visits**	Date of Visits	

Next appointment _____ Your hospital/clinic **number** _____

Reason for visits _____

_____

What **treatment** did you receive? _____

_____

What **doctors** do you see at this hospital/clinic on a regular basis? _____

_____

If you need more space, use Remarks, Section 9, on Page 9.

F. Does **anyone else have medical records or information** about your illnesses, injuries, or conditions (Workers' Compensation, insurance companies, prisons, attorneys, welfare), or are you scheduled to see anyone else?

❑ **Yes** ❑ **No** **(If yes, complete information below)**

Name			DATES
Address			**First Visit**
City	State	Zip	**Last Seen**
Phone ( )			**Next Appointment**
Claim Number (if any)			
Reasons for visits			

If you need more space, use Remarks, Section 9, on Page 9.

Section 5. Medications

Do you currently take any **medications** for your illnesses, injuries, or conditions? ❑ Yes ❑ No
If **yes**, please tell us the following (look at your medicine bottles, if necessary).

Name of Medicine	If Prescribed, Give Name of Doctor	Reason for Medicine	Side Effects You Have

If you need more space, use Remarks, Section 9, on Page 9.

Section 6. Test

Have you had, or will you have, any **medical tests** for your illnesses, injuries, or conditions? ❑ Yes ❑ No
If **yes**, please tell us the following: (Give approximate dates, if necessary.)

Kind of Test	When Done or When It Will Be Done (Month, Day, Year)	Where Done? (Name of Facility)	Who Sent You for This Test?
EKG (heart test)			
Treadmill (exercise test)			
Cardiac Catheterization			
Biopsy – name of body part _____			
Hearing Test			
Vision Test			
IQ Test			
EEG (brain wave test)			
HIV Test			
Blood Test (not HIV)			
Breathing Test			
X-ray – name of body part _____			
MRI/CT Scan – name of body part _____			

If you have had other tests, list them in Remarks, Section 9, on Page 9.

Section 7. Education/Training Information

A. Check the highest grade of school completed.

Grade school:

0	1	2	3	4	5	6	7	8	9	10	11	12	GED
❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑

College:

1	2	3	4 or more
❑	❑	❑	❑

Approximate **date** completed: _____

B. Did you attend **special education** classes? ❑ Yes ❑ No (If **no**, go to part C.)

Name of School		Telephone Number ( )	
Street	City	State	Zip Code
Dates Attended From _____ To _____		Type of Program	

C. Have you completed any type of **special training**, **trade** or **vocational school**? ❑ Yes ❑ No

If **yes**, what type? _____

_____

Approximate date completed _____

Section 8. Vocational Rehabilitation Information

A. Have you received services from **Vocational Rehabilitation** or any other organization to help you get back to work? ❑ Yes ❑ No (If **no**, go to part B.)

Name of Organization		Name of Counselor	
Street	City	State	Zip Code
Daytime Phone Number ( )	Type of Program		
Dates Seen From _____ To _____			
Types of Services or Test Performed (IQ, vision, physicals, hearing, workshops, etc.)			

B. Would you like to receive rehabilitation services that could help you get back to work? ❑ Yes ❑ No

Section 9. Remarks

Use this section to add information you did not show in earlier parts of the form. When you are done with this section (or if you don't have anything to add), be sure to go to the next page and complete the signature block.

Section 10. Authorization

READ CAREFULLY: I authorize the Department of Human Services to release information from my records, as necessary, to process my claim as follows:

- Copies of my medical records including any mental health information or substance abuse information may be furnished to a physician or a medical institution for background information if it is necessary for me to have a medical examination by that physician or medical institution. The results of any such examination may be given to my personal physician.
- Information from my records including any mental health information or substance abuse information may also be furnished, if necessary, to any company providing any clerical and administrative services for the purposes of transcribing, typing, copying or otherwise clerically servicing such information. The Iowa Vocational Rehabilitation Services may also have access to information in my records to determine my eligibility for rehabilitative services.

I understand that I may review the disclosed information by contacting the agency or individual releasing the information.

I understand and concur with the statement and authorization given above, except as follows:

(If there are no exceptions, write **none** in the space below. If you do not concur with any part of the above statement, state your objections clearly.):

I have signed two *Authorization to Disclose Information to the Iowa Department of Human Services*, form 470-4459 or 470-4459(S). It has been explained to me that these blank authorizations will be used for additional medical sources that DDS becomes aware of in processing my claim or for contacting a current or past employer. It is agreeable with me for DDS to complete the authorization with the name/address of the employer or medical source and the date of treatment.

I understand that this authorization, except for action already taken, may be voided by me at any time by submitting a written request to the Department of Human Services. If I do not void this authorization, it will automatically end when a final decision is made on my application. If I am already receiving benefits, the authorization will end when a final decision is made as to whether I can continue to receive benefits.

Applicant's Name (please print)		Date
Applicant's Signature		Date
Telephone Number (daytime) ( )	Telephone Number (evening) ( )	Best time to reach you?
Applicant's Legal Representative's Signature		

Only claimant 18 years of age or older, or legal representative, can authorize release of mental health information.

Only claimant, regardless of age, can authorize release of substance abuse information.

Original – Disability Determination Services
Copy – DDS forwards to source
Copy – Client

Section 11. For DHS Use Only. Do Not Write Below This Line.	
Name of Applicant	Social Security Number

OBSERVATIONS/PERCEPTIONS

How was the interview conducted? ❑ Face-to-face with applicant ❑ No contact with applicant

If the claimant had difficulty with the following, check the "yes" block and explain in "observations" or check "no" or "not observed/perceived." (Explain any "no" answers that you think would assist the DDS in making a decision.)

1.	Hearing	❑ Yes	❑ No	❑ Not observed/perceived
2.	Reading	❑ Yes	❑ No	❑ Not observed/perceived
3.	Breathing	❑ Yes	❑ No	❑ Not observed/perceived
4.	Understanding	❑ Yes	❑ No	❑ Not observed/perceived
5.	Coherency	❑ Yes	❑ No	❑ Not observed/perceived
6.	Concentrating	❑ Yes	❑ No	❑ Not observed/perceived
7.	Talking	❑ Yes	❑ No	❑ Not observed/perceived
8.	Answering	❑ Yes	❑ No	❑ Not observed/perceived
9.	Sitting	❑ Yes	❑ No	❑ Not observed/perceived
10.	Standing	❑ Yes	❑ No	❑ Not observed/perceived
11.	Walking	❑ Yes	❑ No	❑ Not observed/perceived
12.	Seeing	❑ Yes	❑ No	❑ Not observed/perceived
13.	Using hands	❑ Yes	❑ No	❑ Not observed/perceived
14.	Writing	❑ Yes	❑ No	❑ Not observed/perceived
15.	Other (specify):			

OBSERVATIONS