Iowa Department of Human Services

Disability Report for Children

FILLING OUT THIS REPORT

If you need help completing any part of this form, contact your Department of Human Services office. Ask your income maintenance worker to help you.

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

- Please fill out this form before your interview appointment.
- Print or type.
- If your appointment is for an interview by telephone, have this form ready to discuss with us when we call you.
- If your appointment is for an interview in our office, bring the completed form with you.
- When we ask for certain numbers, such as dates and telephone numbers, we provide spaces to fill in. Please complete all spaces.
- Be sure to explain an answer if an explanation is requested or needed.
- If more space is needed to answer any of the questions, please use the "REMARKS" section and show the number of the question being answered.

If you already have any of the child's medical records at home, please send them to our office with your completed forms or bring them with you to your interview. If you need the records back, tell us and we will photocopy them and return them to you.

You do not need to ask the child's doctors or hospitals for any reports 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 from whom to request medical and other records. If you cannot remember the names and addresses of any of the child's doctors or hospitals, or the dates of treatment, try to get this information from the telephone book, or from the child's medical bills or prescriptions.

PLEASE REMOVE THIS SHEET BEFORE RETURNING THE COMPLETED FORM.

Iowa Department of Human Services

Disability Report for Children

Section 1. Identifying Information

A.	Print **Name of Child** (first, last, middle initial)		B. Social Security Number	
C.	Show Any **Other Names** Child Has Used			
D.	**Your Name** (if representing an agency, provide agency name)			
E.	Your **Mailing Address** (Apt. No., Rural Route, or P.O. Box, if any)	City	State	Zip Code

F. **Daytime telephone number** where you can be reached. (If you do not have a telephone, give us a daytime telephone number where a message can be left for you.) (_____) _____

G. Your **relationship to child** _____

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

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

I. Does the **child live with you**? ❑ Yes (**Go to L.)** ❑ No (**Continue to next question**.)

If the child does not live with you who, **does child live with**? _____

Name		**This Person's** Relationship to Child	
Address Number and Street (Apt. No., Rural Route, or P.O. Box, if any)	City	State	Zip Code

J. Can this person speak and understand English? ❑ Yes ❑ No If no, what language does this person speak? _____

Can this person read and understand English? ❑ Yes ❑ No

K. Daytime telephone number where this person can be reached. (If this person does not have a telephone, give us a daytime telephone number where a message can be left.) (_____) _____

L. What is the child's height without shoes (length if under age 2)? _____

M. What is the child's weight without shoes? _____

If the child is under age 1, what was the child's weight at birth? _____

Section 2. The Child's Illnesses or Injuries

A. What are the child's **disabling illnesses or injuries**? _____

_____

_____

_____

_____

_____

_____

B. When did the child become **disabled**? Month _____ Day _____ Year _____

C. Does the child have any **pain** related to the child's illnesses or injuries? ❑ Yes ❑ No

Section 3. Medical Assistance

Does the child have a **medical assistance card**? (for example: Medicaid) ❑ Yes ❑ No

If **Yes**, enter the medical assistance number here _____

Section 4. The Child's Medical Treatment

A. Has the child ever been seen by a **health care professional** (for example: a doctor, psychologist, or therapist) for the child's illnesses or injuries? ❑ Yes ❑ No

B. Since the child became disabled has the child been seen by a health care professional for a **mental illness**? ❑ Yes ❑ No

If **Yes**, be sure to include this health care professional in your answers in Section 5.

If you answered No to questions A. and B. above, skip all of Section 5 and go on to Section 6.

Section 5. Medical Sources

Please tell us who may have medical records or other information about the child's illnesses or injuries. Include doctors, hospitals, clinics, and any other people or organizations (like social services, Vocational Rehabilitation, attorneys). Also include any sources the child will be seeing in the future.

List each source separately. This form has room for six sources. If you have more than six, list the others in **Section 9. Remarks**. After you have listed all the sources, go to Section 6 on page 9.

START WITH THE SOURCE WHO KNOWS THE MOST ABOUT THE CHILD'S ILLNESSES OR INJURIES.

A. FIRST SOURCE

Is this source a: ❑ Doctor ❑ Hospital or Clinic ❑ Agency ❑ Other _____
(Specify)

Name of Source	**Address** (Number and Street, Apt. No. (if any), P.O. Box or Rural Route)	
City	State	Zip Code
Patient/Clinic/ID/Claim Number (if known)	Name of Counselor/Caseworker/Therapist (if any)	
Telephone Number ( )	Please show the date of the child's next appointment (if any) Month _____ Day _____ Year _____	

If this source is a **doctor, agency, or other**, complete the information in the following space:

Date first seen: _____ (Month) _____ (Day) _____ (Year) **Date last seen:** _____ (Month) _____ (Day) _____ (Year)

Frequency of Visits:

❑ Weekly ❑ Every two weeks ❑ Monthly ❑ Every two months ❑ Quarterly ❑ Less frequently

Medical Specialty (if doctor) _____

If this source is a **HOSPITAL OR CLINIC**, was the child:

❑ An **inpatient**? (stayed at least overnight)
If checked, enter the beginning and ending dates.

Beginning Date:

Month _____ Day _____ Year _____

Ending Date:

Month _____ Day _____ Year _____

Department: _____

❑ An **outpatient**? (sent home the same day)
If checked, enter the dates first and last seen below.

First Seen:

Month _____ Day _____ Year _____

Last Seen:

Month _____ Day _____ Year _____

Department: _____

Show dates of any **emergency room visits**:

Month _____ Day _____ Year _____

Month _____ Day _____ Year _____

If source is DOCTOR, HOSPITAL or CLINIC, **for what illnesses or injuries was the child seen**?

_____

_____

_____

If source is DOCTOR, HOSPITAL or CLINIC, **what was done, and what treatment was received**?

_____

_____

_____

Show any additional sources on the following pages, one at a time. If you need more space, use Section 9. Remarks. When you finish listing all medical sources, go to Section 6 on page 9.

B. SECOND SOURCE

Is this source a: ❑ Doctor ❑ Hospital or Clinic ❑ Agency ❑ Other _____
(Specify)

Name of Source	**Address** (Number and Street, Apt. No. (if any), P.O. Box or Rural Route)	
City	State	Zip Code
Patient/Clinic/ID/Claim Number (if known)	Name of Counselor/Caseworker/Therapist (if any)	
Telephone Number ( )	Please show the date of the child's next appointment (if any) Month _____ Day _____ Year _____	

If this source is a **doctor, agency, or other**, complete the information in the following space:

Date first seen: _____ (Month) _____ (Day) _____ (Year) **Date last seen:** _____ (Month) _____ (Day) _____ (Year)

Frequency of Visits:

❑ Weekly ❑ Every two weeks ❑ Monthly ❑ Every two months ❑ Quarterly ❑ Less frequently

Medical Specialty (if doctor) _____

If this source is a **HOSPITAL OR CLINIC**, was the child:

❑ An **inpatient**? (stayed at least overnight)
If checked, enter the beginning and ending dates.

Beginning Date:

Month _____ Day _____ Year _____

Ending Date:

Month _____ Day _____ Year _____

Department: _____

❑ An **outpatient**? (sent home the same day)
If checked, enter the dates first and last seen below.

First Seen:

Month _____ Day _____ Year _____

Last Seen:

Month _____ Day _____ Year _____

Department: _____

Show dates of any **emergency room visits**:

Month _____ Day _____ Year _____

Month _____ Day _____ Year _____

If source is DOCTOR, HOSPITAL or CLINIC, **for what illnesses or injuries was the child seen**?

_____

_____

_____

If source is DOCTOR, HOSPITAL or CLINIC, **what was done, and what treatment was received**?

_____

_____

_____

If the child has no other medical sources, go to Section 6 on page 9.

C. THIRD SOURCE

Is this source a: ❑ Doctor ❑ Hospital or Clinic ❑ Agency ❑ Other _____
(Specify)

Name of Source	**Address** (Number and Street, Apt. No. (if any), P.O. Box or Rural Route)	
City	State	Zip Code
Patient/Clinic/ID/Claim Number (if known)	Name of Counselor/Caseworker/Therapist (if any)	
Telephone Number ( )	Please show the date of the child's next appointment (if any) Month _____ Day _____ Year _____	

If this source is a **doctor, agency, or other**, complete the information in the following space:

Date first seen: _____ (Month) _____ (Day) _____ (Year) **Date last seen:** _____ (Month) _____ (Day) _____ (Year)

Frequency of Visits:

❑ Weekly ❑ Every two weeks ❑ Monthly ❑ Every two months ❑ Quarterly ❑ Less frequently

Medical Specialty (if doctor) _____

If this source is a **HOSPITAL OR CLINIC**, was the child:

❑ An **inpatient**? (stayed at least overnight)
If checked, enter the beginning and ending dates.

Beginning Date:

Month _____ Day _____ Year _____

Ending Date:

Month _____ Day _____ Year _____

Department: _____

❑ An **outpatient**? (sent home the same day)
If checked, enter the dates first and last seen below.

First Seen:

Month _____ Day _____ Year _____

Last Seen:

Month _____ Day _____ Year _____

Department: _____

Show dates of any **emergency room visits**:

Month _____ Day _____ Year _____

Month _____ Day _____ Year _____

If source is DOCTOR, HOSPITAL or CLINIC, **for what illnesses or injuries was the child seen**?

_____

_____

_____

If source is DOCTOR, HOSPITAL or CLINIC, **what was done, and what treatment was received**?

_____

_____

_____

If the child has no other medical sources, go to Section 6 on page 9.

D. FOURTH SOURCE

Is this source a: ❑ Doctor ❑ Hospital or Clinic ❑ Agency ❑ Other _____
(Specify)

Name of Source	**Address** (Number and Street, Apt. No. (if any), P.O. Box or Rural Route)	
City	State	Zip Code
Patient/Clinic/ID/Claim Number (if known)	Name of Counselor/Caseworker/Therapist (if any)	
Telephone Number ( )	Please show the date of the child's next appointment (if any) Month _____ Day _____ Year _____	

If this source is a **doctor, agency, or other**, complete the information in the following space:

Date first seen: _____ (Month) _____ (Day) _____ (Year) **Date last seen:** _____ (Month) _____ (Day) _____ (Year)

Frequency of Visits:

❑ Weekly ❑ Every two weeks ❑ Monthly ❑ Every two months ❑ Quarterly ❑ Less frequently

Medical Specialty (if doctor) _____

If this source is a **HOSPITAL OR CLINIC**, was the child:

❑ An **inpatient**? (stayed at least overnight)
If checked, enter the beginning and ending dates.

Beginning Date:

Month _____ Day _____ Year _____

Ending Date:

Month _____ Day _____ Year _____

Department: _____

❑ An **outpatient**? (sent home the same day)
If checked, enter the dates first and last seen below.

First Seen:

Month _____ Day _____ Year _____

Last Seen:

Month _____ Day _____ Year _____

Department: _____

Show dates of any **emergency room visits**:

Month _____ Day _____ Year _____

Month _____ Day _____ Year _____

If source is DOCTOR, HOSPITAL or CLINIC, **for what illnesses or injuries was the child seen**?

_____

_____

_____

If source is DOCTOR, HOSPITAL or CLINIC, **what was done, and what treatment was received**?

_____

_____

_____

If the child has no other medical sources, go to Section 6 on page 9.

E. FIFTH SOURCE

Is this source a: ❑ Doctor ❑ Hospital or Clinic ❑ Agency ❑ Other _____
(Specify)

Name of Source	**Address** (Number and Street, Apt. No. (if any), P.O. Box or Rural Route)	
City	State	Zip Code
Patient/Clinic/ID/Claim Number (if known)	Name of Counselor/Caseworker/Therapist (if any)	
Telephone Number ( )	Please show the date of the child's next appointment (if any) Month _____ Day _____ Year _____	

If this source is a **doctor, agency, or other**, complete the information in the following space:

Date first seen: _____ (Month) _____ (Day) _____ (Year) **Date last seen:** _____ (Month) _____ (Day) _____ (Year)

Frequency of Visits:

❑ Weekly ❑ Every two weeks ❑ Monthly ❑ Every two months ❑ Quarterly ❑ Less frequently

Medical Specialty (if doctor) _____

If this source is a **HOSPITAL OR CLINIC**, was the child:

❑ An **inpatient**? (stayed at least overnight)
If checked, enter the beginning and ending dates.

Beginning Date:

Month _____ Day _____ Year _____

Ending Date:

Month _____ Day _____ Year _____

Department: _____

❑ An **outpatient**? (sent home the same day)
If checked, enter the dates first and last seen below.

First Seen:

Month _____ Day _____ Year _____

Last Seen:

Month _____ Day _____ Year _____

Department: _____

Show dates of any **emergency room visits**:

Month _____ Day _____ Year _____

Month _____ Day _____ Year _____

If source is DOCTOR, HOSPITAL or CLINIC, **for what illnesses or injuries was the child seen**?

_____

_____

_____

If source is DOCTOR, HOSPITAL or CLINIC, **what was done, and what treatment was received**?

_____

_____

_____

If the child has no other medical sources, go to Section 6 on page 9.

F. SIXTH SOURCE

Is this source a: ❑ Doctor ❑ Hospital or Clinic ❑ Agency ❑ Other _____
(Specify)

Name of Source	**Address** (Number and Street, Apt. No. (if any), P.O. Box or Rural Route)	
City	State	Zip Code
Patient/Clinic/ID/Claim Number (if known)	Name of Counselor/Caseworker/Therapist (if any)	
Telephone Number ( )	Please show the date of the child's next appointment (if any) Month _____ Day _____ Year _____	

If this source is a **doctor, agency, or other**, complete the information in the following space:

Date first seen: _____ (Month) _____ (Day) _____ (Year) **Date last seen:** _____ (Month) _____ (Day) _____ (Year)

Frequency of Visits:

❑ Weekly ❑ Every two weeks ❑ Monthly ❑ Every two months ❑ Quarterly ❑ Less frequently

Medical Specialty (if doctor) _____

If this source is a **HOSPITAL OR CLINIC**, was the child:

❑ An **inpatient**? (stayed at least overnight)
If checked, enter the beginning and ending dates.

Beginning Date:

Month _____ Day _____ Year _____

Ending Date:

Month _____ Day _____ Year _____

Department: _____

❑ An **outpatient**? (sent home the same day)
If checked, enter the dates first and last seen below.

First Seen:

Month _____ Day _____ Year _____

Last Seen:

Month _____ Day _____ Year _____

Department: _____

Show dates of any **emergency room visits**:

Month _____ Day _____ Year _____

Month _____ Day _____ Year _____

If source is DOCTOR, HOSPITAL or CLINIC, **for what illnesses or injuries was the child seen**?

_____

_____

_____

If source is DOCTOR, HOSPITAL or CLINIC, **what was done, and what treatment was received**?

_____

_____

_____

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

Section 6. Medications and Tests

A. Has the child taken any **medication** for an illness or injury? ❑ Yes ❑ No

If **Yes**, please tell us the following:

Name of Medication	**Prescribed By** (Name of Health Care Professional)	**Reason for Medication**	**Side Effects** (If any)

B. Has the child had or is the child scheduled to have any of the following medical tests? ❑ Yes ❑ No

If **Yes**, please tell us the following:

Test (Check if **Yes**)	**When Done**		**When Scheduled**		**Where** (Name of Facility)	**Who Ordered Test?**
	Month	Year	Month	Year		
❑ EKG (heart test)						
❑ Treadmill (exercise test)						
❑ Cardiac Catheterization (heart test)						
❑ Biopsy (**Name part of body**):						
❑ Vision test						
❑ Hearing test						
❑ Speech or language test						
❑ IQ testing						

Test (Check if **Yes**)	**When Done**		**When Scheduled**		**Where** (Name of Facility)	**Who Ordered Test?**
	Month	Year	Month	Year		
❑ EKG (brain wave test)						
❑ HIV test						
❑ Other blood test						
❑ Breathing test						
❑ MRI (**Name part of body**):						
❑ CAT Scan (**Name part of body**):						
❑ X-Ray (**Name part of body**):						
❑ Other tests (**Name below**):						
❑ Other tests (**Name below**):						

Section 7. Other Sources

A. Has the child ever been **tested or evaluated** by any of the following agencies (do not repeat medical test information from Question 6) or do any of these agencies have **medical records or information** about the child?

Public or Community Health Department	❑ Yes	❑ No
Child Welfare or Social Services Agency	❑ Yes	❑ No
Developmental Evaluation Center	❑ Yes	❑ No
Mental Health or Mental Retardation Center	❑ Yes	❑ No
Title V Program for Children with Special Health Care Needs	❑ Yes	❑ No
Women, Infants and Children (WIC) Program	❑ Yes	❑ No
Any Other Agency	❑ Yes	❑ No

If you answered **Yes** to any of the above agencies, please **complete the following information for each agency**. If you need more room, enter the information in **Section 9. Remarks**.

Name of Agency			
Address	City	State	Zip Code
Name of Counselor, Caseworker, Therapist, etc. (if known)	Telephone Number ( )		
Type of Test or Evaluation, if any (for example: vision, hearing, speech, physical, psychological or emotional)			
Child's ID or Claim Number	Dates of Test or Evaluation		
Name of Agency			
Address	City	State	Zip Code
Name of Counselor, Caseworker, Therapist, etc. (if known)	Telephone Number ( )		
Type of Test or Evaluation, if any (for example: vision, hearing, speech, physical, psychological or emotional)			
Child's ID or Claim Number	Dates of Test or Evaluation		
Name of Agency			
Address	City	State	Zip Code
Name of Counselor, Caseworker, Therapist, etc. (if known)	Telephone Number ( )		
Type of Test or Evaluation, if any (for example: vision, hearing, speech, physical, psychological or emotional)			
Child's ID or Claim Number	Dates of Test or Evaluation		

B. Has the child been cared for by a **babysitter**:

❑ YES (Complete information to right)

❑ NO (Continue to next question)

Name of Babysitter		
Street Address		
City	State	Zip Code
Telephone Number ( )		
Dates attended:		
From: Month Year	**To:** Month Year	

C. Has the child attended any type of **preschool, daycare, or after school program**?

❑ YES (Complete information to right)

❑ NO (Continue to next question)

Name of Program		
Street Address		
City	State	Zip Code
Telephone Number ( )		
Dates attended:		
From: Month Year	**To:** Month Year	

D. Has the child **attended school**?

❑ YES (Complete information to right)
If there are more than two schools, enter the information in **Section 9. Remarks**.

❑ NO (Continue to next question)

Name of School		
Street Address		
City	State	Zip Code
Telephone Number ( )		
Dates attended:		
From: Month Year	**To:** Month Year	
Grades		
Teacher's Name		

D. Continued

Name of School		
Street Address		
City	State	Zip Code
Telephone Number ( )		
Dates attended:		
From: Month Year	**To:** Month Year	
Grades		
Teacher's Name		

E. **Has the child been in a special education program?**

❑ YES (Complete information to right)

❑ NO (Continue to next question)

Type of Program	
Dates began and ended (if completed):	
From: Month Year	**To:** Month Year
Number of hours per week:	

F. **Has the school made any other special accommodations** for the child? (for example: adaptive furniture, wheelchair ramps, extra assistance or attention)

❑ YES (Complete information to right)

❑ NO (Continue to next question)

Type of Accommodation
Date the accommodation started: Month Year

G. Do you have a copy of the child's **individualized education plan (IEP)**, the report in which the teacher outlines the child's problems and lists the plans for correcting them?

❑ YES (Please provide a copy)

❑ NO (Continue to next question)

Name and town of Area Education Agency that has child's records

H. Has the child received any **special counseling or tutoring**?

❑ YES (Complete information to right)

❑ NO (Continue to next question)

If **Yes**, is the counseling or tutoring received: ❑ In school ❑ Outside of school		
Type of Counseling or Tutoring		
Name of Counselor or Tutor		
Street Address		
City	State	Zip Code
Telephone Number ( )		
Dates began and ended (if completed):		
From: Month Year	**To:** Month Year	
Frequency of visits:		

I. Does the child or family have a **child welfare, social services or early intervention caseworker**?

❑ YES (Complete information to right)

❑ NO (Continue to next question)

Name of Caseworker		
Organization		
Street Address		
City	State	Zip Code
Telephone Number ( )		
File or Record Number		
Date first saw caseworker: Month Year		
Date last saw caseworker: Month Year		

J. Do you have a copy of the child's **individualized family services plan (IFSP)**, the report that identifies the child's needs and the services to be provided to help the child develop?

❑ YES (Please provide a copy)

❑ NO (Continue to next question)

K. Has the child received any **special therapy** (physical, speech and language, occupational), **exercises, or any other services** for the child's illnesses or injuries? Include information about any therapy or exercises the child receives from the parent, guardian, a caregiver, or in school.

- ❑ YES (Complete information to right)
- ❑ NO (Continue to next question)

Name of Therapist		
Street Address		
City	State	Zip Code
Telephone Number ( )		
Person Who Prescribed Designed Therapy		
Type of Therapy		
Frequency of Therapy		
Date therapy began:	Month	Year
Date therapy ended (if completed):	Month	Year
Name of Therapist		
Street Address		
City	State	Zip Code
Telephone Number ( )		
Person Who Prescribed Designed Therapy		
Type of Therapy		
Frequency of Therapy		
Date therapy began:	Month	Year
Date therapy ended (if completed):	Month	Year

L. **Has the child ever worked** (including sheltered work)?

- ❑ YES (Complete information to right)
- ❑ NO (Continue to next question)

If **Yes**, has the child worked since the child became disabled?

- ❑ YES (Complete information to right)
- ❑ NO (Continue to next question)

Employer's Name		
Supervisor or Job Coach's Name		
Street Address		
City	State	Zip Code
Telephone Number ( )		
Briefly describe the work:		

M. Has the child received **vocational rehabilitation services**?

- ❑ YES (Complete information to right)
- ❑ NO (Continue to next question)

If **No**, and the child is at least age 15, would the child like to be referred for rehabilitation or other services that could help the child get a job?

Name of Counselor		
Street Address		
City	State	Zip Code
Telephone Number ( )		
Type of Service Received		
Date service began:	Month	Year
Date service ended (if completed):	Month	Year

N. Has the child ever been involved with the **court system** other than in custody proceedings?

❑ YES (Complete information to right)

❑ NO (Continue to next question)

Note: Providing information about the child's involvement with the court system is optional.

Youth Development Center's Name		
Street Address		
City	State	Zip Code
Probation or Parole Officer's Name		
Street Address		
City	State	Zip Code
Telephone Number ( )		
How Often Involved		
Date last seen: Month Year		

O. Has the child participated in any **community or school activities**, such as choir, boy's or girl's club, scouts, or sports?

❑ YES (Complete information to right)

❑ NO (Continue to next question)

Type of Activity		
Name of Individual Who Supervises Activity		
Street Address		
City	State	Zip Code
Telephone Number ( )		
Date involvement began: Month Year		
Date involvement ended (if completed): Month Year		
If involvement ended, explain why:		

Section 8. Contact Information

A. Please give us the name, address, and daytime telephone number of **someone (other than the child's doctor) who knows about the child's illnesses or injuries** and can help you, if necessary, with the child's claim, including perhaps, bringing the child to a special examination:

Name	**Street Address** (Number and Street, Apt. No. (if any), P.O. Box or Rural Route)	
City	State	Zip Code
Daytime Telephone Number ( )		
B. Can we discuss the child's illnesses or injuries with this person? ❑ Yes ❑ No	C. If the person is related to the child, what is the relationship?	

Section 9. Remarks

Section 9. Remarks (Continued)

Section 10. Remarks and 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. 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. It is agreeable with me for DDS to complete the authorization with the name and address of the 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 a claimant 18 years of age or older, or legal representative, can authorize release of mental health information. Only the claimant, regardless of age, can authorize release of substance abuse information.

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