DWS-ESD 354

Rev. 03/2015

State of Utah
Department of Workforce Services
MEDICAID DISABILITY ADDENDUM

D02418900130105

Disability Medicaid Team
DMD Specialist

Disability Medicaid Team Phone #:
Ph: (801) 245-4848
Toll # 1-877-824-6531
Fax: (801) 526-9339

Return Address:
DWS/DMD
Midvale CIU 500
PO Box 31431
SLC, UT 84131-9988

Medicaid ID or PID _____

Case # _____

The following sections need to be completed in detail by the applicant or applicant's representative. Please use a black pen to complete the form. Return the completed form within 10 days to your local DWS office or mail/fax to the address/fax number listed above.

Applicant's Information

1. Name: _____ SS#: _____
   First Middle Last

   Birth Date: _____ Phone#: _____

   Address: _____
   Street City State ZIP

2. What is the applicant's disabling condition? (Describe the illness or injury in your own words.)

   _____

   _____

   _____

3. Has the applicant ever applied for, received or been denied disability by the Social Security Administration? ☐ Yes ☐ No If the applicant has applied, list date of application: _____

   If currently receiving, list date of first payment: _____

   If denied, when? _____ Why denied? _____

   Is the applicant currently appealing a Social Security denial? ☐ Yes ☐ No

If the applicant is a child, please disregard questions 4 and 5. Use questions 12 and 13 for description of current activities.

4. When did the condition prevent the applicant from working? Month: _____ Year: _____

5. **Work History** – List the jobs the applicant has had in the past 15 years. Use a separate sheet if necessary.

Job Title (List most recent job first, include job duties/tasks)	Name or Type of Company	Dates Worked (Month and Year)		Days per Week
		From	To	

6. **Education** – What is the highest school grade completed and when? (month/year) _____

List any special training (trade schools, technical courses, etc.) _____

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7. Indicate the doctor/facility that has the latest medical records about the applicant's disabling condition.

Doctor: _____ Phone#: _____
First Last
Facility name (if applicable): _____ FAX#: _____
Address: _____
Street City State Zip
How often does the applicant see this doctor? _____
Date applicant first saw this doctor: _____ Date applicant last saw this doctor: _____
Reason for visit? (Show illness or injury for which applicant had an examination or treatment.) _____

8. List any other doctors the applicant has seen in the last 12 months:

Doctor: _____ Phone#: _____
First Last
Facility name (if applicable): _____ FAX#: _____
Address: _____
Street City State Zip
How often does the applicant see this doctor? _____
Date applicant first saw this doctor: _____ Date applicant last saw this doctor: _____
Reason for visit? (Show illness or injury for which applicant had an examination or treatment.) _____

Doctor: _____ Phone#: _____
First Last
Facility name (if applicable): _____ FAX#: _____
Address: _____
Street City State Zip
How often does the applicant see this doctor? _____
Date applicant first saw this doctor: _____ Date applicant last saw this doctor: _____
Reason for visit? (Show illness or injury for which applicant had an examination or treatment.) _____

9. List the hospitals where the applicant has been treated in the last 12 months:

Name of hospital or clinic: _____ Phone#: _____
Address: _____ FAX#: _____
Street City State Zip
Date of admission: _____ Date of discharge: _____ Date of outpatient visits: _____
Reason for visit? (Show illness or injury for which applicant had an examination or treatment.) _____

10. Other agencies/programs the applicant is involved in:
(Voc Rehab, Mental Health, VA, SSI, etc.)

Name of Agency	Address	Date of Visit(s)

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11. Has the applicant had any of the following tests or procedures in the last year?

Name of Test	Check Box	When (Date)	Where (Facility Name)
Electrocardiogram and/or exercise test	☐ Yes ☐ No		
X-Rays (Indicate areas – chest, knee, etc.)	☐ Yes ☐ No		
Breathing Tests	☐ Yes ☐ No		
Blood Tests	☐ Yes ☐ No		
Surgery/Biopsy (Describe)	☐ Yes ☐ No		
Other (Specify)	☐ Yes ☐ No		

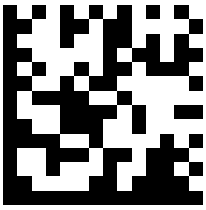
If more space is needed to list other doctors, hospitals, agencies, etc., use a separate sheet.

INFORMATION ABOUT APPLICANT'S ACTIVITIES

12. Describe the applicant's current activities in the following areas. How much/often are they performed?

Household Maintenance: (For example: cooking, cleaning, shopping, paying bills, and performing odd jobs around the house as well as any other similar activities.)
Social Contacts: (For example: visits with friends, relatives, neighbors, attending church, parties, etc.)
Recreational Activities and Hobbies: (For example: hunting, fishing, bowling, hiking, playing musical instruments, eating out, playing cards or board games, going to movies or watching television, etc.)
Other:

13. Use this section for additional information to answer questions from previous sections or if you are applying for a child, use this space to compare the child's activities and abilities to other children the same age.



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Completed By: _____ _____
Signature Date

If completed by person other than applicant, indicate relationship to applicant: _____

STOP

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THIS PAGE TO BE COMPLETED BY SOMEONE WHO HAS KNOWLEDGE OF THE APPLICANT'S LIMITATIONS. FOR EXAMPLE: CASE WORKERS, COUNSELORS, HEALTH AIDES, CLERGY, TEACHERS, RELATIVES, ETC.

NOTE: MEDICAL PROVIDERS WILL NOT BE REIMBURSED FOR COMPLETING THIS PAGE.

OBSERVATIONS: Check any areas where difficulties were observed.

Reading	☐ Yes ☐ No	Seeing	☐ Yes ☐ No
Writing	☐ Yes ☐ No	Using Hands	☐ Yes ☐ No
Hearing	☐ Yes ☐ No	Sitting	☐ Yes ☐ No
Understanding	☐ Yes ☐ No	Walking	☐ Yes ☐ No
Answering	☐ Yes ☐ No	Balance	☐ Yes ☐ No
Breathing	☐ Yes ☐ No	Other (Specify)	_____

If any of the above items were checked "yes", describe in detail the difficulty observed: _____

- Does the applicant speak English? ☐ Yes ☐ No If no, what language is spoken? _____
- What are the applicant's current living arrangements, i.e. lives independently in a home, apartment, etc., or requires assistance, lives with relative, friend, in a group home, etc.?
- Please describe the applicant's ability to function, i.e. ability to understand, remember and follow instructions. Can he/she care for personal needs, shop, manage funds, pay bills? Can he/she interact successfully with others?
- If you are filling out this form or gathering additional information on behalf of the applicant, then list your name, address, phone number and relationship of the individual.

Completed By: _____ _____
Signature Date

Relationship to Applicant: _____