SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Continuing Disability Report - Adult

Send to: SCDHHS-Central Mail
PO Box 100101
Columbia, SC 29202-3101

If you need assistance, please call the Healthy Connections Member Services Center toll free at ***(888) 549-0820 (TTY 888-842-3620)****.*

☐ *File for last favorable decision not found* _____ *(Initials)* Household Number: _____	**THIS BOX FOR DHHS USE ONLY** Initial Application Date: ___ / ___ / ___ (Filing Date on MAO99)	**Number of pages received and scanned:** _____

Please fully complete this form and return with the signed Authorization to Disclose Health Information form in the provided envelope. It is very important that you provide complete addresses and phone numbers for your medical sources. If the form is not completed fully, it will delay the processing of your Medicaid Disability claim.

It is critical that the enclosed Authorization to Disclose Health Information form is signed **IN BLACK OR BLUE INK. If there is a legally appointed representative or power of attorney documentation, please include a copy with your completed and signed form.**

Last Name: _____ First Name: _____ Middle Initial: ___

SSN#:_____-_____-_____ Previous Name/Maiden Name: _____

Date of Birth:_____/_____/_____ Date of Death (If Applicable):_____/_____/_____

Street Address: _____ City: _____ State: ____ ZIP: _____

Phone: _____-_____-_____

Contact Person: _____

Relationship to Applicant: _____ Phone:_____-_____-_____

Contact's Address: _____ City: _____ State: ____ ZIP: _____

What is your preferred spoken or written language (if not English)? _____

What is the disabling condition for which you are receiving Medicaid?

_____

Any change (better or worse) or new injuries or illnesses since you began receiving benefits?

☐ Yes ☐ No If yes, what has changed, and when?

_____

_____

_____

MEDICAL INFORMATION ABOUT YOUR DISABILITY

NOTE: If you need additional space for medical sources, list their names, addresses, and reasons for visits in the "remarks" section. We need a complete address for all medical providers in order to request medical records. List ALL doctors you have seen in a **clinic or doctor's office** in the last **15 months**.

1. Doctor's Name: _____ Clinic: _____
   Address: _____ Phone: _____
   _____ Reason for Visit: _____
   _____ Date last seen: _____
2. Doctor's Name: _____ Clinic: _____
   Address: _____ Phone: _____
   _____ Reason for Visit: _____
   _____ Date last seen: _____
3. Doctor's Name: _____ Clinic: _____
   Address: _____ Phone: _____
   _____ Reason for Visit: _____
   _____ Date last seen: _____
4. Doctor's Name: _____ Clinic: _____
   Address: _____ Phone: _____
   _____ Reason for Visit: _____
   _____ Date last seen: _____
5. Doctor's Name: _____ Clinic: _____
   Address: _____ Phone: _____
   _____ Reason for Visit: _____
   _____ Date last seen: _____

We need the complete address for all medical providers in order to request medical records.

List ALL **hospitals, emergency rooms, or urgent care facilities** you have visited in the last **15 months**. List the name of facility only; we do not need individual names of doctors.

Note: If you need additional space, you may use the "remarks" section or attach additional pages

1. Facility Name: _____ (Circle all that apply) INPATIENT*OUTPATIENT
   Address: _____ Phone: _____
   _____ Reason for Visit: _____
   _____ Date last seen: _____
2. Facility Name: _____ (Circle all that apply) INPATIENT*OUTPATIENT
   Address: _____ Phone: _____
   _____ Reason for Visit: _____
   _____ Date last seen: _____
3. Facility Name: _____ (Circle all that apply) INPATIENT*OUTPATIENT
   Address: _____ Phone: _____
   _____ Reason for Visit: _____
   _____ Date last seen: _____
4. Facility Name: _____ (Circle all that apply) INPATIENT*OUTPATIENT
   Address: _____ Phone: _____
   _____ Reason for Visit: _____
   _____ Date last seen: _____
5. Facility Name: _____ (Circle all that apply) INPATIENT*OUTPATIENT
   Address: _____ Phone: _____
   _____ Reason for Visit: _____
   _____ Date last seen: _____

List any additional places where you have had tests or imaging (blood work, xrays, CTs, etc) performed in the last 15 months **if facility has not already been listed above**.

1. Facility Name: _____ Date last seen: _____

   Address: _____ Phone: _____

   _____ Test/Image: _____

   _____ _____

2. Facility Name: _____ Date last seen: _____

   Address: _____ Phone: _____

   _____ Test/Image: _____

   _____ _____

3. Facility Name: _____ Date last seen: _____

   Address: _____ Phone: _____

   _____ Test/Image: _____

   _____ _____

In the last 15 months, have you been evaluated or treated by any of the following agencies?

☐ Yes ☐ No SC Dept. of Mental Health Clinic Facility: _____

☐ Yes ☐ No Alcohol and Drug Facility Facility: _____

☐ Yes ☐ No SC Dept. of Disabilities & Special Needs Facility: _____

EDUCATION HISTORY

What is the highest grade you **COMPLETED? (Circle option that applies)**

6^{th} grade or less 7^{th}-11^{th} grade 12^{th} grade/GED

Were you enrolled in Special Education or Resource classes? ☐ YES ☐ NO

If yes, what type of classes did you attend? (Example: resource, math, reading, etc): _____

_____

Name of school: _____

Address: _____

_____

Dates Attended: _____ Phone number: _____

WORK HISTORY

Have you worked in the last 15 years? ☐ YES ☐ NO
If yes, please complete the following questions **for each type of job** you held in the last 15 years. If you need additional space, you can attach additional pages.

*(Regarding **TYPE OF WORK** example: worked as a maid and also as a cook. If you were a maid, but at several different companies, this is considered one TYPE of work).*

1. Job Title/Type: _____

I held this job from / / to / / . Please describe what you did in this job: _____

In this job, how many total hours each day did you (**circle answer that most applies**)

WALK	Less than 2	2-6	6-8	8+
STAND	Less than 2	2-6	6-8	8+
SIT	Less than 2	2-6	6-8	8+
CLIMB	Less than 2	2-6	6-8	8+
STAND	Less than 2	2-6	6-8	8+
STOOP	Less than 2	2-6	6-8	8+

KNEEL	Less than 2	2-6	6-8	8+
CROUCH	Less than 2	2-6	6-8	8+
CRAWL	Less than 2	2-6	6-8	8+
HANDLE/GRASP	Less than 2	2-6	6-8	8+
WRITE/TYPE	Less than 2	2-6	6-8	8+
LIFT/CARRY	Less than 2	2-6	6-8	8+

What did you lift/carry and how far did you carry it?

What is the heaviest weight lifted?

☐ Less than 10 lbs ☐ 10 lbs ☐ 20 lbs ☐ 50 lbs ☐ 100 lbs or more ☐ Other: _____

What is the weight most frequently lifted?

☐ Less than 10 lbs ☐ 10 lbs ☐ 20 lbs ☐ 50 lbs ☐ 100 lbs or more ☐ Other: _____

2. Job Title/Type: _____

I held this job from / / to / / . Please describe what you did in this job: _____

In this job, how many total hours each day did you (**circle answer that most applies**)

WALK	Less than 2	2-6	6-8	8+
STAND	Less than 2	2-6	6-8	8+
SIT	Less than 2	2-6	6-8	8+
CLIMB	Less than 2	2-6	6-8	8+
STAND	Less than 2	2-6	6-8	8+
STOOP	Less than 2	2-6	6-8	8+

KNEEL	Less than 2	2-6	6-8	8+
CROUCH	Less than 2	2-6	6-8	8+
CRAWL	Less than 2	2-6	6-8	8+
HANDLE/GRASP	Less than 2	2-6	6-8	8+
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What is the weight most frequently lifted?

☐ Less than 10 lbs ☐ 10 lbs ☐ 20 lbs ☐ 50 lbs ☐ 100 lbs or more ☐ Other_____

WORK HISTORY, CONTINUED

3. Job Title/Type: _____

I held this job from / / to / / . Please describe what you did in this job: _____

In this job how many total hours each day did you (**circle answer that most applies**):

WALK	Less than 2	2-6	6-8	8+
STAND	Less than 2	2-6	6-8	8+
SIT	Less than 2	2-6	6-8	8+
CLIMB	Less than 2	2-6	6-8	8+
STAND	Less than 2	2-6	6-8	8+
STOOP	Less than 2	2-6	6-8	8+

KNEEL	Less than 2	2-6	6-8	8+
CROUCH	Less than 2	2-6	6-8	8+
CRAWL	Less than 2	2-6	6-8	8+
HANDLE/GRASP	Less than 2	2-6	6-8	8+
WRITE/TYPE	Less than 2	2-6	6-8	8+
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_____

What is the heaviest weight lifted?

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What is the weight most frequently lifted?

☐ Less than 10 lbs ☐ 10 lbs ☐ 20 lbs ☐ 50 lbs ☐ 100 lbs or more ☐ Other: _____

4. Job Title/Type: _____

I held this job from / / to / / . Please describe what you did in this job: _____

_____

In this job, how many total hours each day did you (**circle answer that most applies**)

WALK	Less than 2	2-6	6-8	8+
STAND	Less than 2	2-6	6-8	8+
SIT	Less than 2	2-6	6-8	8+
CLIMB	Less than 2	2-6	6-8	8+
STAND	Less than 2	2-6	6-8	8+
STOOP	Less than 2	2-6	6-8	8+

KNEEL	Less than 2	2-6	6-8	8+
CROUCH	Less than 2	2-6	6-8	8+
CRAWL	Less than 2	2-6	6-8	8+
HANDLE/GRASP	Less than 2	2-6	6-8	8+
WRITE/TYPE	Less than 2	2-6	6-8	8+
LIFT/CARRY	Less than 2	2-6	6-8	8+

What did you lift/carry and how far did you carry it?

_____

What is the heaviest weight lifted?

☐ Less than 10 lbs ☐ 10 lbs ☐ 20 lbs ☐ 50 lbs ☐ 100 lbs or more ☐ Other: _____

What is the weight most frequently lifted?

☐ Less than 10 lbs ☐ 10 lbs ☐ 20 lbs ☐ 50 lbs ☐ 100 lbs or more ☐ Other: _____

REMARKS

Use this space to provide additional information that may help make a decision on your disability claim.

Please remember to sign and return the Authorization to Disclose Health Information form, Form 921.

Notice of Non-Discrimination

The South Carolina Department of Health and Human Services (SCDHHS) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. SCDHHS does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

SCDHHS provides free aids and services to people with disabilities, such as qualified sign language interpreters and written information in other formats (large print, braille, audio, accessible electronic formats, other formats). We provide free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, please contact the Americans with Disabilities Act (ADA)/Civil Rights Official by mail at: PO Box 8206, Columbia, SC 29202-8206, by phone at: 1-888-549-0820 (TTY: 1-888-842-3620), or by email at: civilrights@scdhhs.gov.

If you believe SCDHHS has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Civil Rights Official using the contact information provided above. You can file a grievance in person, by mail, or via email. If you need help filing a grievance, we are available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201 or by phone at: 800-368- 1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html