SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Disability Report - Adult

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

This box for pilot use only
☐ Presumptive Disability
☐ DD Workflow Pilot

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

FOR DHHS USE ONLY

Number of pages received and scanned: _____

☐ Adult Initial ☐ Retro Only Date of Last Update: _____

Household Number: _____ Application Date: _____ Retro: _____

☐ Working Disabled

Please fully complete this form and return with the signed Authorization to Disclose Health Information form. 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 INK. If there is a legally appointed representative or power of attorney documentation, please include a copy with your completed and signed form.**

Information about you: ☐ Male ☐ Female ☐ Prefer Not to Answer

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

SSN#: _____ Previous Name/Maiden Name: _____

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

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

Home Phone: _____ Cell Phone: _____

Contact Person: _____

Relationship to Applicant: _____ Phone: _____

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

Your Language:

Do you speak English? ☐ Yes ☐ No
Do you understand English? ☐ Yes ☐ No
Do you read English? ☐ Yes ☐ No
Do you write in English? ☐ Yes ☐ No

What is your first language (if not English)? _____
Can you read in your first language? ☐ Yes ☐ No
Can you write in your first language? ☐ Yes ☐ No

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

IMPORTANT:

1. Have you applied for Supplemental Security Income (SSI) Disability Benefits? ☐ Yes ☐ No
   a. If yes, date of application: _____
   b. Has your medical condition changed? ☐ Yes ☐ No
   c. Do you have new doctors since you applied for SSI Disability Benefits? ☐ Yes ☐ No
   d. Was an application made in SC? ☐ Yes ☐ No If no, what state? _____
2. Have you applied for Social Security benefits? ☐ Yes ☐ No
   a. If yes, date of application: _____
   b. Has your medical condition changed? ☐ Yes ☐ No
   c. Do you have new doctors since you applied for Social Security Benefits? ☐ Yes ☐ No
   d. If denied by SSA, have you asked them to reconsider your claim? ☐ Yes ☐ No
      Did SSA refuse to reconsider your claim? ☐ Yes ☐ No
      Did you request an appeal or hearing? ☐ Yes ☐ No

What is your disability?

List and describe all your medical and mental health problems. Include those that affect your ability to work.

List your Medical and/or Mental Health Problems	Date problem started	Medications/Treatments

Information about all of your medical and mental health providers:

Please list all medical and mental health providers that treated any of your listed health problems in the last 15 months. A medical or mental health provider may include a doctor, psychologist, therapist, social worker, physical therapist, chiropractor, hospital, emergency room, health center, and clinic from which you receive treatment. For every provider you list, you will need to submit copies of your medical records (as medical history, care or treatments received, test results, diagnoses, and medications taken) for the past 15 months.

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 listed providers in case any additional information is needed.

	Provider's Name	Address	Clinic Name	Reason for Visit	Date Last Seen
1					
					Phone
2					Date Last Seen
					Phone
3					Date Last Seen
					Phone
4					Date Last Seen
					Phone
5					Date Last Seen
					Phone

	Provider's Name	Address	Clinic Name	Reason for Visit	Date Last Seen
6					
					Phone
7					**Date Last Seen**
					Phone
8					**Date Last Seen**
					Phone
9					**Date Last Seen**
					Phone

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? (Check option that applies)**

☐K ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐11 ☐12 ☐GED ☐ Higher than 12th grade

Name of school: _____

Address: _____

Dates attended: _____ Phone number: _____

Did you receive any special help or accommodation in school? ☐ Yes ☐ No ☐ Not Sure

Do you have a learning disability? ☐ Yes ☐ No

Did you complete school higher than 12th grade? ☐ Yes ☐ No

If yes, please list your degree and major: _____

Date of completion: _____

Did you get any other training? ☐ Yes ☐ No

If yes, please fill out the section below:

Type of training:	Year	Did you finish?	Are you Certified/Licensed?
_____		☐ Yes ☐ No	_____
_____		☐ Yes ☐ No	_____
_____		☐ Yes ☐ No	_____

WORK HISTORY

Have you worked in the last 5 years? ☐ Yes ☐ No

If yes, please complete the following questions **for each type of job** you held in the last 5 years. Do the best that you can. If you do not know the exact dates, write your best guess. Start with your current job or the most recent job you worked. 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 "Job Title/Type").*

1. **Job Title/Type:** _____

   Dates of Employment: Start Date: _____ End Date: _____

   Hours worked per week: _____ How much did you get paid per hour: _____

   Please describe what you did in this job: _____

   _____

   _____

   _____

   Weight most often lifted/carried (Check One):

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

   Heaviest weight lifted (Check One):

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

   How many hours did you do each of the following per day: Walk_____ Stand_____ Reach_____

   Sit_____ Bend_____ Handle big objects_____ Handle small objects_____

   Reason for leaving: _____

2. **Job Title/Type:** _____

Dates of Employment: Start Date: _____ End Date: _____

Hours worked per week: _____ How much did you get paid per hour: _____

Please describe what you did in this job: _____

_____

_____

_____

Weight most often lifted/carried (Check One):

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

Heaviest weight lifted (Check One):

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

How many hours did you do each of the following per day: Walk_____ Stand_____ Reach_____

Sit_____ Bend_____ Handle big objects_____ Handle small objects_____

Reason for leaving: _____

3. **Job Title/Type:** _____

Dates of Employment: Start Date: _____ End Date: _____

Hours worked per week: _____ How much did you get paid per hour: _____

Please describe what you did in this job: _____

_____

_____

_____

_____

Weight most often lifted/carried (Check One):

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

Heaviest weight lifted (Check One):

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

How many hours did you do each of the following per day: Walk_____ Stand_____ Reach_____

Sit_____ Bend_____ Handle big objects_____ Handle small objects_____

Reason for leaving: _____

4. **Job Title/Type:** _____

Dates of Employment: Start Date: _____ End Date: _____

Hours worked per week: _____ How much did you get paid per hour: _____

Please describe what you did in this job: _____

_____

_____

_____

Weight most often lifted/carried (Check One):

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

Heaviest weight lifted (Check One):

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

How many hours did you do each of the following per day: Walk_____ Stand_____ Reach_____

Sit_____ Bend_____ Handle big objects_____ Handle small objects_____

Reason for leaving: _____

If you have other jobs to add (within the last 5 years), please attach information with this form.

REMARKS

Use this space to provide additional information that may help with making a disability decision.

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

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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.htm