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

☐ Presumptive Disability
This box for pilot use only

If you need assistance, please call the Healthy Connections Member Services Center toll free at ***(888) 549-0820 (TTY 888-849-3620)***.

	FOR DHHS USE ONLY	**Number of pages received and scanned:** _____
☐ Adult Initial ☐ Retro Only	Date of Last Update: ___ / ___ / ___	
Household Number: _______________	Application Date: ___ / ___ / ___	Retro: ___________

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 your disability?

____

____

____

____

____

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 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 your 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

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: ____________________

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: ______________________ INPATIENT OUTPATIENT

   Address: ______________________ Phone: ______________________

   ______________________ Reason for Visit: ______________________

   ______________________ Date last seen: ______________________

2. Facility Name: ______________________ INPATIENT OUTPATIENT

   Address: ______________________ Phone: ______________________

   ______________________ Reason for Visit: ______________________

   ______________________ Date last seen: ______________________

3. Facility Name: ______________________ INPATIENT OUTPATIENT

   Address: ______________________ Phone: ______________________

   ______________________ Reason for Visit: ______________________

   ______________________ Date last seen: ______________________

4. Facility Name: ______________________ INPATIENT OUTPATIENT

   Address: ______________________ Phone: ______________________

   ______________________ Reason for Visit: ______________________

   ______________________ Date last seen: ______________________

5. Facility Name: ______________________ INPATIENT OUTPATIENT

   Address: ______________________ Phone: ______________________

   ______________________ Reason for Visit: ______________________

   ______________________ Date last seen: ______________________

List any additional places where you have had tests or imaging (blood work, x-rays, 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? (Check option that applies)**

☐ 6th grade or less ☐ 7th-11th grade ☐ 12th 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 (**Check 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+
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 (**Check 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+
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+
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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 (**Check 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+
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:

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 (**Check 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+
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:

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.

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 provides free aids and services to people with disabilities, such as qualified sign language interpreters and written information in other formats (including large print, braille, audio, accessible electronic formats, and 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.

Notice of Non-Discrimination

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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.html