



WORK ACTIVITY REPORT (Self-Employed Person)

ND DEPARTMENT OF HUMAN SERVICES
MEDICAL ASSISTANCE
SFN 1077 (Rev. 5/2005)

Send to: State Review Team
ND Department of Human Services
600 E Boulevard Ave, Dept. 325
Bismarck, ND 58505
Fax: (701) 328-1544

Note: This form has 4 pages.

Name of disabled person	Blind Not Blind	Name of Wage Earner (If other than disabled person)
-------------------------	----------------------	---

PAPERWORK REDUCTION ACT: This information collection meets the clearance requirements of 44 U.S.C. §3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You are not required to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take you about 30 minutes to read the instructions, gather the necessary facts, and answer the questions. **SEND THE COMPLETED FORM TO: State Review Team, ND Dept. of Human Services, 600 E. Boulevard Ave, Dept. 325, Bismarck, ND 58505.**

Please use this form to describe your work activity (Date disability began or, if later, date of prior investigation)	Date (to be entered by SRT) 1.
---	--

ANSWER EACH QUESTION AS FULLY AS POSSIBLE

2.	A. List name and address of business (include zip code)											
	B. Please Check if Farm Non-Farm						C. Briefly indicate the primary product or service					
3.	A. Describe the business in terms of arrangement and/or ownership (Check one) Sole Owner Partnership Farm Tenant Farm Landlord											
	B. Give your monthly self-employment income since the above date (average if not sure)											
	Month	Year	Gross	Net	Month	Year	Gross	Net	Month	Year	Gross	Net
	Month	Year	Gross	Net	Month	Year	Gross	Net	Month	Year	Gross	Net
4.	A. Describe (briefly) what you did in the business in terms of management decisions, responsibilities, hours, production and services before your illness or injury.											
	B. Was this business your sole livelihood prior to your illness or injury? YES NO											
5.	Please describe your present work activities and any changes in your business because of your illness or injury. Explain such things as reduced hours of business, lower volume, fewer acres under cultivation or other. (If you use extra help, write "extra help" here and provide the details when you get to item 9.)											

If you need more space for any answer, use Page 3.

6.	Do (did) you make management decisions after your illness or injury? (If "yes," describe the kinds of decisions made, the time spent making them and any changes that have taken place.)	YES	NO
7.	A. If you began your business after you were injured or became ill, did you receive any special assistance from an agency or other source in setting up your business?	YES	NO
	B. Does this assistance continue or have additional special services been supplied? (If "yes," please describe)	YES	NO
8.	A. What is the value or any normal business expense which you do (did) not pay including that which is furnished or paid for by another person or organization (such as free space or utilities)? Why were such items supplied to you for free and by whom were they furnished?		
	B. Describe any special expenses related to your illness or injury that you paid which are necessary for you to work (for example, attendant care, medical devices, equipment, prostheses, or similar items or services.)		
DESCRIBE ANY ADDITIONAL HELP YOU NEED (NEEDED) IN PERFORMING YOUR USUAL DUTIES BECAUSE OF YOUR ILLNESS OR INJURY.			
9.	A. Number of assistants		B. Time they devoted to helping you
	C. What do (did) they do?		
	D. Are/were assistants (check one) PAID UNPAID		E. If paid, how much?
	F. Is (are) assistant(s) related to you? (check one) YES NO		
	G. Why was the additional help needed?		

Use this section for additional space to answer any previous questions and to give any additional information you think will be helpful. Please refer to the previous questions by number, such as 4A or 4B or 5.

10.

If more space is needed, use an extra sheet of paper.

PLEASE READ THE FOLLOWING STATEMENT, THEN SIGN, DATE AND PROVIDE ADDRESS AND TELEPHONE NUMBER.

I certify under penalty of law that the information on this form is true.

Signature of claimant/beneficiary or representative		Date
Mailing address (Number and Street, Apt. Number, P.O. Box, or Rural Route)	State	Zip Code
County	Telephone Number	

FOR STATE USE ONLY

11.	A. Contact made: (check one)	IN PERSON	BY MAIL	BY TELEPHONE
	B. Completed by: (check one)	CLAIMANT	DEPT REPRESENTATIVE	OTHER
	C. If "Other" show			
Address (include zip code)				
Phone Number (include area code)				
12.	Interviewer/reviewer check list. Check all that apply:			
	A. Unpaid business expenses (Rent, utilities, etc.)		YES	NO
	B. Impairment-related work expenses		YES	NO
	C. Unpaid help, or business sponsored by an agency		YES	NO
	D. Unsuccessful work attempt (CDI - no medical issue - DO jurisdiction for a final determination)		YES	NO
	E. Unsuccessful work attempt (DO recommendation only - DDS jurisdiction for a final determination.)		YES	NO
	F. Substantial gainful activity		YES	NO
Rationale:				
13.	Signature of interviewer or reviewer	Title	DO Code	Date