MEDICAID EXPANSION WORK REQUIREMENT
MEDICALLY FRAIL EXCLUSION

DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 120 (9-2026)

Click Here to Clear Field Data

Complete this form and attach current medical records that explain how the condition limits the individual's ability to work, attend school, or volunteer.

* Indicates Required Fields

INDIVIDUAL INFORMATION

*First Name	*Last Name	*Date of Birth - MM/DD/YYYY
Medicaid Number - If Known	Telephone Number	Email Address
Street Address	City	State / ZIP Code
Specify Preferred Method of Contact		

QUALIFYING QUESTION

Which of the following conditions limit the individuals ability to work, attend school, or volunteer? Select all that apply:

- ☐ Serious or Complex Medical Condition
- ☐ Physical, Developmental, or Intellectual Disability
- ☐ Disabling Mental Disorder - Specify Disorder: _____
- ☐ Substance Use Disorder
- ☐ None

CONDITIONS AND LIMITATIONS

*List Current Condition or Conditions
*Explain How the Condition Limits Work, School, or Volunteering

TREATING PROVIDER

*Treating Provider or Clinic	Provider Telephone Number

SUPPORTING MEDICAL RECORDS

For your application to be reviewed, medical records must be attached. Attach records from the treating provider for the past six months. The records should describe how the health conditions limit their ability to work, attend school or volunteer.

Examples include but are not limited to:

- History and Physical Report
- In-patient or Discharge Records
- Clinic or Progress Notes
- Mental Health or Substance Use Treatment Records
- Physical Therapy or Occupational Therapy Evaluations
- A letter from your treating provider must also include records to show your health condition limitations on your ability to work, attend school or volunteer.

Are all records attached from the previous six months?
◯ Yes ◯ No

SUBMIT COMPLETED FORM AND RECORDS TO ONE OF THE FOLLOWING WAYS

EMAIL: medicallyfrail@nd.gov

FAX: 701.328.1544

In Person at the Individuals Human Service Zone Office

MAIL: DHHS Medical Services
600 East Boulevard Ave Dept 325
Bismarck ND, 58505

PERSON COMPLETING FORM ON THE INDIVIDUALS BEHALF

Complete this section if the form was completed by a guardian or another authorized representative acting on behalf of the individual.

Full Name		Relationship to the Individual
Agency	Telephone Number	Email Address

CERTIFICATION

☐ *I certify by selecting this box I have read and agree that the information on this form is true and complete to the best of my knowledge. Incomplete or unsupported requests may be denied, and requested information must be returned within 30 days. A denied Individual may reapply with new documentation or changed circumstances.

*Individual or Authorized Representative Signature	*Date