WORKERS WITH DISABILITIES REPORT-PART II

DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 228 (6-2024)

Clear Fields

42 U.S.C. 1320b-7 requires all persons requesting Medicaid to provide their social security number or show that they have applied for one; failure to provide this information will cause the person to be ineligible for assistance. The social security number is used to check the identity of household members, to prevent duplicate participation, to monitor compliance with program regulations, for claim collection, for official examinations by Federal or State agencies, and to help make mass changes. The social security number is also used to check information in our records against other Federal, State or local government computer matching systems participating in the Income and Eligibility Verification System, including but not limited to the IRS, SSA, Department of Labor and TANF, which may affect eligibility and the level of benefits.

Section 1 - Information About the Working Disabled Person

Name (First, Middle Initial, Last)		Social Security Number	Date of Birth
Daytime Telephone Number	Height Without Shoes	Weight Without Shoes	Sex ☐ Male ☐ Female

Specify the name of a friend or relative that we can contact (other than your doctors) who knows about your illnesses, injuries, or conditions and can help you with your claim.

Name	Relationship	Daytime Telephone Number	
Address	City	State	ZIP Code

Can you speak English? ☐ Yes ☐ No	If no, what languages can you speak?	Can you read English? ☐ Yes ☐ No	Can you write more than your name in English? ☐ Yes ☐ No

If you **cannot speak English**, give us the name of someone we may contact who speaks English and will give you messages.
If this is the same person identified above, show "SAME" here.

Name	Relationship	Daytime Telephone Number	
Address	City	State	ZIP Code

Section 2 - Your Illnesses, Injuries, or Conditions and How They Affect You

Explain the illnesses, injuries, or conditions that affect your ability to work	
Explain how your illnesses, injuries, or conditions affect your ability to work	
Do your illnesses, injuries, or conditions cause you pain? ☐ Yes ☐ No	Date your illnesses, injuries, or conditions first bothered you
Date you first became limited with your work because of your illnesses, injuries, or conditions	
Check the following changes caused by your illnesses, injuries, or conditions (check all that apply and provide an explanation below): ☐ Work fewer hours ☐ Change your job duties ☐ Make any job-related changes such as your attendance, help needed, or employers	
Explain the Change(s) Checked Above	

Section 3 - Information About Your Work

List the jobs that you have had since your illnesses, injuries, or conditions

JOB TITLE (Example: Cook)	TYPE OF BUSINESS (Example: Restaurant)	DATES WORKED (Month/Year)		HOURS PER WEEK	DAYS PER WEEK	RATE OF PAY (Per hour, day, week, month, or year)
		FROM	TO			

Describe the job from the previous question that you did the longest. (What do you do in this job?)

Mark the appropriate answer for the job described above. (Check all that apply)

- Use machines, tools or equipment ☐ Yes ☐ No
- Use technical knowledge or skills ☐ Yes ☐ No
- Perform writing, completing reports, or any similar duties ☐ Yes ☐ No
- Supervise other people ☐ Yes ☐ No
- If yes, was supervision your main duty? ☐ Yes ☐ No

Enter the number of hours you did each of the following activities:

Walk	Stand	Sit	Climb	Stoop (bend at waist)	Kneel (bend legs to rest on knees)	Crouch (bend legs & back down & forward)	Crawl	Handle, grab, or grasp big objects	Write, type, or handle small objects

Explain what you lifted, how far you carried it, and how often you did lifting and carrying

Heaviest Weight Lifted

☐ Less than 10 lbs ☐ 10 lbs ☐ 20 lbs ☐ 50 lbs ☐ 100 lbs ☐ Other (specify):

Weight Frequently Lifted (1/3 to 2/3 of the workday)

☐ Less than 10 lbs ☐ 10 lbs ☐ 25 lbs ☐ 50 lbs or More ☐ Other (specify):

Section 4 - Information About Your Medical Records

Have you been seen by a doctor/hospital/clinic or anyone else for the illnesses, injuries, or conditions that limit your work?

☐ Yes ☐ No

Have you been seen by a doctor/hospital/clinic or anyone else for the emotional or mental problems that limit your work?

☐ Yes ☐ No

If you answered "No" to both of the questions above, go to Section 5

List other names you have used on your medical records.

List each Doctor/HMO/Therapist who may have medical records or other information about your illnesses, injuries, or conditions.

Name of Doctor/HMO/Therapist	Chart/HMO Number	Date of First Visit		Date of Last Visit	Date of Next Appointment
Address	City		State	ZIP Code	Telephone Number

Reasons for Visit

Explain Treatment Received

Name of Doctor/HMO/Therapist	Chart/HMO Number	Date of First Visit	Date of Last Visit	Date of Next Appointment
Address	City	State	ZIP Code	Telephone Number
Reasons for Visit				
Explain Treatment Received				

Name of Doctor/HMO/Therapist	Chart/HMO Number	Date of First Visit	Date of Last Visit	Date of Next Appointment
Address	City	State	ZIP Code	Telephone Number
Reasons for Visit				
Explain Treatment Received				

If you need more space, use Section 9 - Remarks

List each Hospital/Clinic Visited

Name of Hospital/Clinic	Telephone Number	Your Hospital/Clinic Number	Date of Next Appointment
Address	City	State	ZIP Code
Type of Visit ☐ Inpatient Stays (Stayed overnight) ☐ Outpatient Visits (Sent home same day) ☐ Emergency Room Visits			
Date of First Visit	Dates of Visits		
Reasons for Visit			
Explain Treatment Received			
List the doctors at this hospital/clinic you see on a regular basis			

Name of Hospital/Clinic	Telephone Number	Your Hospital/Clinic Number	Date of Next Appointment

Address	City	State	ZIP Code

Type of Visit
☐ Inpatient Stays (Stayed overnight) ☐ Outpatient Visits (Sent home same day) ☐ Emergency Room Visits

Date of First Visit	Dates of Visits

Reasons for Visit

Explain Treatment Received

List the doctors at this hospital/clinic you see on a regular basis

If you need more space, use Section 9 - Remarks

Does anyone else have medical records or information about your illnesses, injuries, or conditions (Workforce Safety and Insurance, insurance companies, prisons, attorneys, welfare), or are you scheduled to see anyone else?
☐ Yes - Complete Information Below ☐ No

Name	Claim Number	Date of First Visit	Date of Last Visit	Date of Next Appointment

Address	City	State	ZIP Code	Telephone Number

Reasons for Visit

If you need more space, use Section 9 - Remarks

Section 5 - Medications

List any medications you are currently taking for your illnesses, injuries, or conditions. (Look at your medicine bottles, if necessary)

NAME OF MEDICINE	IF PRESCRIBED, NAME OF DOCTOR	REASON FOR MEDICINE	SIDE EFFECTS YOU HAVE

If you need more space, use Section 9 - Remarks

Section 6 - Medical Tests

List any medical tests you had or will have for your illnesses, injuries, or conditions.
If you have had other tests, list them in Section 9 - Remarks

KIND OF TEST	DATE OF TEST (Month/Day/Year)	NAME OF FACILITY WHERE TESTED	WHO SENT YOU FOR THE TEST
EKG (Heart Test)			
TREADMILL (Exercise Test)			
CARDIAC CATHERITIZATION			
BIOPSY - List body part			
HEARING TEST			
VISION TEST			
IQ TESTING			
EEG (Brain Wave Test)			
HIV TEST			
BLOOD TEST (Not HIV)			
BREATHING TEST			
X-RAY - List body part			
MRI/CT SCAN - List body part			

Section 7 - Education/Training Information

A. Last Grade Completed ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐11 ☐12 ☐GED			College ☐1 ☐2 ☐3 ☐4 or more
Approximate Date Completed	B. Attended any special education classes ☐Yes ☐No - Go to Question C.	Name of School	
Address	City	State	ZIP Code
Type of Program	Date Started Attending the School	Last Date Attended the School	
C. Completed any type of special job training, trade or vocational school ☐Yes ☐No			
Type of Special Job Training, Trade or Vocational School		Approximate Date Completed	

Section 8 - Vocational Rehabilitation Information

Have you received services from Vocational Rehabilitation or any other organization to help you to work? ☐Yes-Complete Below: ☐No - Go to Section 9			
Name of Organization	Name of Counselor	Daytime Telephone Number	
Address	City	State	ZIP Code
Type of Services or Tests Performed (IQ, vision, physicals, hearing, workshops, etc.)		Dates Seen From: To:	

Section 9 - Remarks

Use this section for any added information you did not show in earlier parts of the form.

Signature of claimant or person filing on claimant's behalf (parent, guardian)	Date

Witnesses are required ONLY if this statement has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the person making the statement must sign below, giving their full addresses.

Signature of Witness			Signature of Witness		
Address			Address		
City	State	ZIP Code	City	State	ZIP Code

AUTHORIZATION TO DISCLOSE INFORMATION TO THE NORTH DAKOTA DEPARTMENT OF HEALTH AND HUMAN SERVICES (NDDHHS) STATE REVIEW TEAM

Name of Person Whose Records Are to be Disclosed	
Social Security Number	Date of Birth

42 U.S.C. 1320b-7 requires all persons requesting Medicaid to provide their social security number or show that they have applied for one; failure to provide this information will cause the person to be ineligible for assistance. The social security number is used to check the identity of household members, to prevent duplicate participation, to monitor compliance with program regulations, for claim collection, for official examinations by Federal or State agencies, and to help make mass changes. The social security number is also used to check information in our records against other Federal, State or local government computer matching systems participating in the Income and Eligibility Verification System, including but not limited to the IRS, SSA, Department of Labor and TANF, which may affect eligibility and the level of benefits.

HHS USE ONLY

Name of Number Holder (if different from above)
Case Number

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange) of **All my medical records; also education records and other information related to my ability to perform tasks. This includes specific permission to release:**

1. All records an other information regarding my treatment, hospitalization, and outpatient care for my impairment(s) including, and not limited to:
   -- Psychological, psychiatric or other mental impairment(s)
   -- Drug abuse, alcoholism, or other substance abuse
   -- Sickle cell anemia
   -- Human immunodeficiency virus (HIV) infection (including acquired immunodeficiency syndrome (AIDS) or test for HIV or sexually transmitted diseases
   -- Gene-related impairments (including genetic test results)
2. Information about how my impairment(s) affects my ability to complete tasks, activities of daily living, and affects specific functions in the work environment.
3. Copies of educational tests or evaluations, including Individualized Educational Programs, triennial assessments, psychological and speech evaluations, and any other records that can help evaluate function; also teachers' observations and evaluations.
4. Information created within 12 months after the date this authorization is signed, as well as past information.

THIS BOX TO BE COMPLETED BY NDDHHS (as needed). List additional information to identify the subject (e.g., other names used), the specific source, or the material to be disclosed.

FROM WHOM
* All medical sources (hospitals, clinics, labs, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, and VA health care facilities
* All educational sources (schools, teachers, records administrators, counselors, etc.)
* Social workers/rehabilitation counselors
* Consulting examiners used by NDDHHS
* Employers
* Others who may know about my condition (family, friends, public officials)

TO WHOM
The State agency authorized to process my case, including contract copy services and doctors or other professionals consulted during the process.

PURPOSE
Determining my eligibility for benefits, under Workers With Disabilities Program, including looking at the combined effect of any impairments that by themselves would not meet NDMA's definition of working disability.

EXPIRES WHEN This authorization is good for 12 months from the date signed.
* I authorize the use of a copy (including electronic copy) of this form for the disclosure of information described above.
* I understand that there are some circumstances where this information may be redisclosed to other parties.
* I may write to NDDHHS to revoke this authorization at any time.
* NDDHHS will give me a copy of this form if I ask; I may ask the source to allow me to inspect or get a copy of material to be disclosed.
* I have read this form and agree to the disclosure above from the types of sources listed.

Signature of Individual Authorizing Disclosure	Parent/Guardian Signature (if two signatures are required by law)
If not signed by subject of disclosure, specify basis for authority to sign ☐ Parent of Minor ☐ Parent of Minor ☐ Other Personal Representative (Explain):	
Date Signed	Address
Telephone Number	City / State / ZIP Code

Signature of Witness that knows the person signing this form			IF Needed, Second Witness Signature (i.e., if signed with "X" above)		
Telephone Number	Address		Telephone Number	Address	
City	State	ZIP Code	City	State	ZIP Code