ELIGIBILITY REPORT ON DISABILITY/INCAPACITY

DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 451 (9-2024)

Clear Fields

CHECK ONE:

- ☐ Incapacity
- ☐ Disability
- ☐ JOBS Good Cause
- ☐ Workers with Disability
- ☐ Child with Disabilities (Include SFN 228)
- ☐ Emergency Services

I. CASE INFORMATION

Case Name			Spaces/Case Number	Medicaid ID Number
Address			Date of Application	
City	State	ZIP Code	Medical Request Date	

II. FINANCIAL OR MEDICAL ASSISTANCE INFORMATION

THE INFORMATION IS REGARDING PERSON WHOSE DISABILITY/INCAPACITY IS THE BASIS FOR ELIGIBILITY.

Name	Birth Date

Sex	Race				Marital Status		
☐ Male ☐ Female	☐ Asian	☐ Hispanic	☐ White		☐ Single	☐ Married	☐ Divorced
	☐ African American	☐ Native American	☐ Other				

Education (check highest grade completed)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ 13 ☐ 14 ☐ 15 ☐ 16

Types of degrees, training and/or education

If individual has been a patient at a state institution, provide name and dates of entry and release

BENEFITS

☐ SSA (Specify Type):	Date Applied:	Date of Entitlement:
☐ SSI	Date Applied:	Date of Entitlement:
☐ VA	Date Applied:	Date of Entitlement:
☐ Worker's Compensation	Date Applied:	Date Began Receiving:
☐ Unemployment Benefits	Date Applied:	Date Began Receiving:
☐ Other (Specify):		

Do you have an appeal pending with Social Security? ☐ Yes ☐ No

Employment: List the employment the individual has engaged in, dates of employment, place of employment, and the duties of the job, beginning with the most recent (go back five years only).

Date Employment Terminated and Reason for Termination: Was the termination discussed with previous employer and what were his/her comments?

How does the individual's health impairment limit his/her ability to perform his/her role as the primary supporter or caretaker?
When would he/she be able to return to that role?
Current occupation of spouse or significant other?

III. FAMILY UNIT

Give name, age, and relationship of all members of the family and any other individuals who may be in the home.

IV. HEALTH SITUATION

Chief complaints and present illness as stated by the applicant/recipient: (Applicant's/recipient's comments only)
(Reserved for Eligibility Worker Comments): Describe fully the physical or mental problem(s) as observed by the worker (include information on mobility, degree of functional impairment, and personal services needed in activities of daily living). Give dates of onset of impairment, what limbs are affected, and any other objective observations noted by the worker, such as: Uses crutches, needs a cane, drags leg, arm appears stiff, etc.
Signature of Eligibility Worker (Must be signed and dated before sending to DHHS)

Title	Date
Human Service Zone Name	Fax Number (number that the SRT decision will be sent to)