ELIGIBILITY REPORT ON DISABILITY/INCAPACITY

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 451 (3-2015)

Clear Fields

PLEASE CHECK ONE:

- ☐ Incapacity
- ☐ Disability
- ☐ JOBS Good Cause
- ☐ Aid to the Blind - Remedial
- ☐ Workers with Disability (Include SFN 228)
- ☐ Child with Disabilities
- ☐ Emergency Services

I. CASE INFORMATION

Case Name:			TECS/TEEM 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: ☐ Male ☐ Female

Race: ☐ Asian ☐ African American ☐ Hispanic ☐ Native American ☐ White ☐ Other

Marital Status: ☐ Single ☐ Married ☐ Divorced

Education: (Check highest grade completed)
☐ 0 ☐ 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 authorized person and title:	County:	Date: