



## MaineCare Disability Determination

### What is a MaineCare disability determination?

This form is a request for a MaineCare disability determination. It is a supplement to the MaineCare application. A MaineCare disability determination is the Medical Review Team's decision whether you meet the Social Security Administration's definition of disability. Those who are determined to meet that definition may be eligible for MaineCare based on that determination.

### Who can complete the form?

This form should be filled out by you or an adult member of your household, or a relative, friend, or authorized representative who is familiar with your medical history. If you would like to appoint an authorized representative to act on your behalf, you may do so by filling out an Appointment of Representation form, available at any regional office or online at <http://www.maine.gov/dhhs/ofi/forms.shtml>.

### What information do I need to provide?

You need to list all your health care providers, along with contact information and a Release of Information form, found at the end of this form, for each provider you list. It is important that the information you provide is complete and accurate.

### Do I need to see a doctor?

If you have not had any medical or psychological appointments in the last 12 months, you need to find a provider and schedule an evaluation appointment. DHHS will pay for this appointment. You will need to tell us the date and time of this appointment, and the provider's name and contact information.

### What if I have questions about the form?

Please call 1-855-797-4357 if you have any questions about this form.

### Do I need to complete a MaineCare application?

If you do not already have MaineCare, you need to complete a MaineCare application. Applications can be found at any regional office, or online at <http://www.maine.gov/dhhs/ofi/public-assistance/>. You can also apply for MaineCare online at <https://www1.maine.gov/benefits/account/login.html>.

### When you have completed this form, please do the following:

- 1) Please double-check that you have filled out the entire form. Completing the form thoroughly is necessary for the Medical Review Team (MRT) to process your request. If you need more space, please use the space provided at the end of this document. You may also submit additional pages if needed.

### THE SOCIAL SECURITY ADMINISTRATION'S DEFINITION FOR BEING DISABLED

"The law defines disability as the inability to engage in any substantial gainful activity (SGA) by reason of any medically determinable physical or mental impairment(s) which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months."

Source:

<https://www.ssa.gov/disability/professionals/bluebook/general-info.htm>

- 2) Make sure there is a release for each provider you have listed, and that the release forms include your name, date of birth, and initials in each of the four spaces authorizing release of information.
- 3) Contact your provider(s) to let them know that you have requested a MaineCare disability determination. Please tell your providers(s) that we will be requesting medical records from them. The providers' prompt cooperation in providing clear and complete information is essential for timely processing.
- 4) If you already have medical records, please provide copies of those records with this form.
- 6) Please contact the Office for Family Independence at 1-855-797-4357 if any of the following occur:
  - a. Your address or phone number changes
  - b. You return to work, even if only temporarily
  - c. You see a new doctor or mental health provider
  - d. You go to the hospital
  - e. Your condition changes or a new condition develops
- 7) Mail the completed form, along with completed Releases of Information to the following address:  
Farmington District Office  
114 Corn Shop Lane  
Farmington, ME 04938

### **Nondiscrimination Statement**

The Department of Health and Human Services ("DHHS") does not discriminate on the basis of disability, race, color, sex, gender, sexual orientation, age, national origin, religious or political belief, ancestry, familial or marital status, genetic information, association, previous assertion of a claim or right, or whistleblower activity, in admission or access to, or the operation of its policies, programs, services, or activities, or in hiring or employment practices.

This notice is provided as required by and in accordance with Title II of the Americans with Disabilities Act of 1990 ("ADA"); Title VI of the Civil Rights Act of 1964, as amended; Section 504 of the Rehabilitation Act of 1973, as amended; Age Discrimination Act of 1975; Title IX of the Education Amendments of 1972; Section 1557 of the Affordable Care Act; the Maine Human Rights Act; Executive Order Regarding State of Maine Contracts for Services; and all other laws and regulations prohibiting such discrimination.

Questions, concerns, complaints or requests for additional information regarding the ADA and hiring or employment practices may be forwarded to the DHHS ADA/EEO Coordinators at 11 State House Station, Augusta, Maine 04333-0011; 207-287-4289 (V); 207-287-1871(V); or Maine Relay 711 (TTY). Questions, concerns, complaints or requests for additional information regarding the ADA and programs, services, or activities may be forwarded to the DHHS ADA/Civil Rights Coordinator, at 11 State House Station, Augusta, Maine 04333-0011; 207-287-5014 (V); Maine Relay 711 (TTY); or ADA-CivilRights.DHHS@maine.gov. Civil rights complaints may also be filed with the U.S. Department of Health and Human Services, Office of Civil Rights, by phone at 800-368-1019 or 800-537-7697 (TDD); by mail to 200 Independence Avenue, SW, Room 509, HHS Building, Washington, D.C. 20201; or electronically at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>.

Individuals who need auxiliary aids for effective communication in program and services of DHHS are invited to make their needs and preferences known to the ADA/Civil Rights Coordinator. This notice is available in alternate formats, upon request.

**Please tear off and keep this page for your records.**

**SWMA060 (R04/18)**

State of Maine Department of Health and Human Services Disability Determination Form

FOR REGIONAL OFFICE USE ONLY

MaineCare ID Number: \_\_\_\_\_

I. INFORMATION ABOUT THE DISABLED PERSON

Name \_\_\_\_\_

Parent/Guardian name, if under age 18: \_\_\_\_\_

Parent/Guardian phone number, if under age 18: (\_\_\_\_\_) \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Mailing Address (Street, P.O. Box, or RFD): \_\_\_\_\_ Apartment # \_\_\_\_\_

City or Town: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

City or Town where you live (if different): \_\_\_\_\_

Your Telephone Number: (\_\_\_\_\_) \_\_\_\_\_ Sex: Male  Female

Where do you live: House  Apartment  Shelter  Group Home  Boarding Home  Nursing Home   
Homeless  Other  If Other, describe: \_\_\_\_\_

Primary Language: \_\_\_\_\_

Do you read English? Yes  No  Do you speak English? Yes  No

Do you understand English? Yes  No  Do you write English? Yes  No

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

II. INFORMATION ABOUT THE ILLNESS OR INJURY

A. Date your illness or injury first happened:

\_\_\_\_\_  
\_\_\_\_\_

Date unable to work: \_\_\_\_\_

B. What are your illnesses, injuries or conditions? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How do your illnesses, injuries or conditions limit your ability to work? If a child, how do your illnesses, injuries or conditions limit your ability to function as same age peers? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

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C. Check any of the following items that your illnesses, injuries or conditions affect:

- Lifting  Walking  Stair Climbing  Understanding  Squatting  Sitting   
 Seeing  Following Instructions  Bending  Kneeling  Memory   
 Using Hands  Standing  Talking  Completing Tasks   
 Getting Along with Others  Reaching  Hearing  Concentration

D. Please explain how your illnesses, injuries or conditions affect each of the items you checked. (For example, you can only lift [how many pounds], or can walk outside [how far]): \_\_\_\_\_

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**III. DISABILITY BENEFITS**

Have you ever applied for any of the following benefits? YES  NO  (If yes, please indicate below)

Type of Benefit	Date Applied	Date Approved	Date Denied	Still Waiting?
Social Security Disability Income (SSDI)				
Supplemental Security Income (SSI)				
Veteran's Benefits				
MaineCare (Medicaid)				
TANF				
Railroad Retirement				
Other Disability Payment Describe:				

**IV. MEDICAL SOURCES:** Please list all doctors, clinics and hospitals you have visited in the last 12 months. If you have not seen any providers in the last 12 months, skip to Part V.

A. Providers:

1. Primary Care Provider

Name: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

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Date of last appointment: \_\_\_\_\_ Date of next appointment: \_\_\_\_\_

Reason for visit: \_\_\_\_\_

2. Other doctor or mental health provider

Name: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

Date of last appointment: \_\_\_\_\_ Date of next appointment: \_\_\_\_\_

Reason for visit: \_\_\_\_\_

3. Other doctor or mental health provider:

Name: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

Date of last appointment: \_\_\_\_\_ Date of next appointment: \_\_\_\_\_

Reason for visit: \_\_\_\_\_

4. Other doctor or mental health provider:

Name: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

Date of last appointment: \_\_\_\_\_ Date of next appointment: \_\_\_\_\_

Reason for visit: \_\_\_\_\_

**B. Hospital or Clinic**

1. Name of hospital or clinic: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

Did you stay overnight? Yes  No

If Yes, Admission date(s): \_\_\_\_\_ Discharge date(s): \_\_\_\_\_

Did you just visit during the day? Yes  No

If Yes, date of last appointment: \_\_\_\_\_ Date of next appointment: \_\_\_\_\_

Why did you go to the hospital? \_\_\_\_\_

2. Name of hospital or clinic: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

Did you stay overnight? Yes  No

If Yes, Admission date(s): \_\_\_\_\_ Discharge date(s): \_\_\_\_\_

Did you just visit during the day? Yes  No

If Yes, date of last appointment: \_\_\_\_\_ Date of next appointment: \_\_\_\_\_

Why did you go to the hospital? \_\_\_\_\_

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### C. Other

Are you receiving any of the following (please check boxes that apply to you)?:

Occupational Therapy  Chiropractic Services  Physical Therapy  Speech Therapy

Name, Address and Telephone Number of Chiropractor(s) or Therapist(s):

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### V. Schedule an Evaluation Appointment:

If you have not seen a healthcare provider within the last 12 months, you need to find a health care provider and schedule an appointment. Be sure to tell the provider you are applying for a MaineCare disability determination.

Provider Name: \_\_\_\_\_

Provider's Address: \_\_\_\_\_

Provider's Telephone Number: \_\_\_\_\_

We will send the provider a letter, letting them know what information we need from them after the appointment. We will also send the provider a billing form. The Department will pay the provider for this appointment.

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### VI. EDUCATION AND OTHER PROGRAMS

Are you currently in school? Yes  No

If YES, Name of current school: \_\_\_\_\_

Address of current school: \_\_\_\_\_

Name/telephone number of contact person at the school: \_\_\_\_\_

Program of study: \_\_\_\_\_

What is your highest grade of school completed? \_\_\_\_\_

Would you like to be in a job training or vocational education program? Yes  No

Have you ever received services from any of the following (check boxes that apply to you)?

Vocational Rehabilitation  Veterans Administration  Behavioral and Developmental Services

Other Helping Agency  (Describe): \_\_\_\_\_

Please give name(s), address(es) and telephone number(s) of any agencies checked above: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**VII. WORK HISTORY** (If you have worked in the past, this section must be completed)

Have you ever been a wage earner? Yes  No  (If no, Proceed to section **VIII**)

- If you are now employed, how many hours a week do you work? \_\_\_\_\_
- If you are not now working, give the date you last worked: \_\_\_\_\_
- Are you currently getting unemployment benefits? Yes  No
- In your past relevant work, did you use machines, tools or equipment? Yes  No
- Need special skills? Yes  No  Have to write? Yes  No  Supervise other people? Yes  No
- Please list your 3 most recent jobs:

**1.** Job Title: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_

Hours per day: \_\_\_\_\_ Days per week: \_\_\_\_\_ Rate of pay: \$ \_\_\_\_\_ Hour  Day  Week  Month

Describe your job duties: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How often in a day did you have to bend (please circle one): Never Occasionally Frequently Constantly

Weight most often lifted/carried (please circle one): Up to 10 lbs. 25 lbs. 50 lbs. Over 50 lbs.

Heaviest weight lifted (please circle one): 10 lbs. 20 lbs. 50 lbs. 100 lbs. Over 100 lbs.

How many hours did you do each of the following per day: Walk \_\_\_\_\_, Stand \_\_\_\_\_, Sit \_\_\_\_\_,

Handle/grab big objects \_\_\_\_\_ Handle/grab small objects \_\_\_\_\_

**2.** Job Title: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_

Hours per day: \_\_\_\_\_ Days per week: \_\_\_\_\_ Rate of pay: \$ \_\_\_\_\_ Hour  Day  Week  Month

Describe your job duties: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How often in a day did you have to bend (please circle one): Never Occasionally Frequently Constantly

Weight most often lifted/carried (please circle one): Up to 10 lbs. 25 lbs. 50 lbs. Over 50 lbs.

Heaviest weight lifted (please circle one): 10 lbs. 20 lbs. 50 lbs. 100 lbs. Over 100 lbs.

How many did you do each of the following per day: Walk \_\_\_\_\_, Stand \_\_\_\_\_, Sit \_\_\_\_\_,

Handle/grab big objects \_\_\_\_\_ Handle/grab small objects \_\_\_\_\_

3. Job Title: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_

Hours per day: \_\_\_\_\_ Days per week: \_\_\_\_\_ Rate of pay: \$ \_\_\_\_\_ Hour  Day  Week  Month

Describe your job duties: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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How many did you do each of the following per day: Walk \_\_\_\_\_, Stand \_\_\_\_\_, Sit \_\_\_\_\_,

Handle/grab big objects \_\_\_\_\_ Handle/grab small objects \_\_\_\_\_

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### VIII. ACTIVITIES OF DAILY LIVING

- Shop for food and supplies: Yes  No  (If no, please explain)

\_\_\_\_\_

- Prepare meals and wash dishes: Yes  No  (If no, please explain)

\_\_\_\_\_

- Wash and iron clothes: Yes  No  (If no, please explain)

\_\_\_\_\_

- Clean house: Yes  No  (If no, please explain)

\_\_\_\_\_

- Decision making about household management: Yes  No  (If no, please explain)

\_\_\_\_\_

- Care for children: Yes  No  (If no, please explain)

\_\_\_\_\_

Personal Care: Explain how your illnesses, injuries, or conditions affect your ability to care for yourself (For example, dress, bathe, personal hygiene, etc.) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

House and Yard Work: List household chores, both indoors and outdoors, that you can do.(For example, cleaning, laundry, household repairs, mowing, etc.) \_\_\_\_\_

Hobbies and Interests: What are your hobbies and interests? (For example, reading, watching TV, internet, sewing, playing games/sports, etc.) How often and how well do you do these things? \_\_\_\_\_

Social Activities: Do you spend time with others (in person, on the phone, on the computer, etc.)? Yes  No

List the places you go on a regular basis. (For example, church, community center, sports events, concerts, etc.) \_\_\_\_\_

Getting Around: How often do you go outside? \_\_\_\_\_

If you do not go out at all, explain why not: \_\_\_\_\_

When you go out, how do you travel? (Check all that apply)

Walk  Drive a motor vehicle  Ride in a motor vehicle  Use public transportation

Other  (Explain) \_\_\_\_\_

When you go out, can you go out alone? Yes  No

If no, please explain: \_\_\_\_\_

How far can you walk before needing to stop and rest? \_\_\_\_\_

If you must rest, how long before you can resume walking? \_\_\_\_\_

Do you finish what you start? (For example, a TV show, a conversation, chores, etc.): Yes  No

ADDITIONAL INFORMATION



RELEASE OF MEDICAL RECORDS

CLIENT NAME:

DOB:

This form may be copied and sent to the health care providers you list; if you prefer to address them prior to signing, please ensure that the address where your provider stores them is the address you list on the form.

Health Care Provider's Name, Address and Telephone Number

(Please be sure to give us accurate and complete information for requesting medical records, if this information is not correct we will not be able to obtain your medical records, or you may leave this block blank and MRT will complete)

I, [redacted], hereby authorize the above named health care provider to release all medical records concerning the above named client to the Department of Health & Human Services (DHHS) for the past 12 months. I further authorize the named provider to speak to DHHS about those records.

The purpose of this authorization is to provide DHHS with the information it needs to decide whether I or the above named client is disabled, in order to determine if MaineCare and/or TANF benefits should be provided.

Specific information to be released: \_\_\_\_\_

Any information not to be released: \_\_\_\_\_

I understand the following to be true:

- The medical record contains information related to diagnosis and/or treatment, and I authorize the release of all requested information.
If this information is disclosed to a third party, it may no longer be protected by federal or state privacy laws.
I may refuse to disclose all or some of the requested information. However, if I do so, DHHS may deny/close my benefits.
This release is valid whether in the original, a photocopy, facsimile or electronic form.
I may revoke this authorization in writing by contacting DHHS (at the address above) or the Health Care provider. If I do so, I am aware that DHHS may deny/close my benefits. Revoking the authorization will have no effect on the information already released.

I understand that I must give special permission for Mental Health, Drug and/or Alcohol Abuse Treatment, and HIV/AIDS related records to be released. Such information may not be re-disclosed without my specific written consent. Records requested are protected under Federal regulation 42 CFR Part 2, HIPAA and 45 CFR Par 160&164.

[redacted] I DO authorize release of information regarding mental health treatment. (initials required)

[redacted] I DO authorize release of information regarding drug or alcohol abuse treatment. (initials required)

[redacted] I Do authorize release of information regarding HIV/AIDS diagnosis/treatment. (initials required)

[redacted] I DO NOT wish to review any records before they are released. (initials required)

This authorization expires on: [redacted] (no longer than one year. If undated, expires in 90 days from the date signed)

You may choose to sign this form or not. If you do not sign it or if you revoke it before we receive the information we need, we may not be able to decide whether you are disabled. In that case, we may deny or stop your benefits. If the provider doesn't accept this release, you are responsible to get and provide us with the necessary medical records so we can decide if you are disabled.

Client Signature (clients age 13 or over must sign themselves)

Date

Parent/Guardian/Other Authorized Person Signature

Date

Witness

Date



MAINE DHHS – OFFICE FOR FAMILY INDEPENDENCE

Medical Review Team, 114 Corn Shop Lane, Farmington, ME 04938

1-855-797-4357

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