Department of Human Resources 311 West Saratoga Street Baltimore MD 21201	**Family Investment Administration** **ACTION TRANSMITTAL**
Control Number: #11-13	**Effective Date: 12/1/10** **Issuance Date: December 13, 2010**

TO: **DIRECTORS, LOCAL DEPARTMENTS OF SOCIAL SERVICES**
DEPUTY/ASSISTANT DIRECTORS FOR FAMILY INVESTMENT
FAMILY INVESTMENT SUPERVISORS AND ELIGIBILITY STAFF
DIVISION OF ELIGIBILITY WAIVER SERVICES

FROM: **KEVIN M. MCGUIRE, EXECUTIVE DIRECTOR, FIA**
DEBBIE RUPPERT, EXECUTIVE DIRECTOR, DHMH/OES

RE: **LDSS AND DEWS PROCEDURES FOR APPLICANTS AND RECIPIENTS FILING FOR DISABILITY IN AN ABD COVERAGE GROUP**

PROGRAM AFFECTED: **MEDICAL ASSISTANCE**

ORIGINATING OFFICE: **OFFICE OF ELIGIBLITY SERVICES**

SUMMARY:

There are two entities that make Aged Blind and Disabled (ABD) disability determinations: the Social Security Administration (SSA) and the State Review Team (SRT) of the Family Investment Administration (FIA). The SSA and the SRT use a 5 Step sequential evaluation process to determine disability as defined by the SSA.

The SRT includes physicians, psychologists, disability specialists, and clerks. SRT determines an applicant's disability based on the SSA 5 Step evaluation process. Effective 12/1/10, Step 1 of the evaluation process to determine disability is the responsibility of the Local Department of Social Services (LDSS).

This Action Transmittal (AT):

1. Includes a ***Reference Guide*** which outlines procedures for processing Applications, Redeterminations, Reactivations, and Step 1 of the MA ABD Disability Determination.
2. Defines policies for the Disability Determination process and outlines responsibilities of the LDSS and the SRT.
3. Provides clarification regarding who can make disability determinations for Medical Assistance (MA),
4. Outlines procedures for referring cases to SRT.
5. Reminds case managers that **disability determinations made by the SSA remain binding on the State until changed by the SSA.**
6. Clarifies that **State and Federal regulations prohibit the State from making an independent determination of disability during the 90-day period following the individual's MA application date, when there is a pending SSA application.**

Reminder: The SRT receives disability determination referrals statewide and strives to make disability determination case decisions within 60 days when the applicant is ineligible to apply for SSA benefits. Circumstances may warrant a delay or extension of this process. (See page 8 of the *Reference Guide* for delay reason codes.)

The following Action Transmittals and Information Memos are ***OBSOLETE:***

- AT 01-28
- AT 10-16 Retracted (Issuance Date: 12/22/09)
- IM 06-18
- IM 06-18 revised
- IMA OPA # 96-12

The following forms are only ***OBSOLETE*** for Medical Assistance disability determinations:

- DHR/FIA 402-B Medical Report Form
- DHR/FIA 4204 Vocational, Educational and Social Data Form

POLICY:

LDSS MUST COMPLETE STEP 1 OF THE DISABILITY DETERMINATION PROCESS

The LDSS is responsible for processing referrals to SRT, which includes the completion of **Step 1** in the 5 Step evaluation process to determine disability. In order to process referrals, the LDSS must provide a referral packet (or SRT Packet) to the State Review Team consisting of Substantial Gainful Activity (SGA) information, when applicable, and the referral forms listed on page 3.

The LDSS is responsible for evaluating Substantial Gainful Activity, or Step 1 of the evaluation process to determine disability. If an applicant indicates they have earned income, the LDSS must evaluate SGA by assessing whether an individual can engage in significant work activity performed for pay. To determine if an applicant meets or does not meet SGA, the LDSS must calculate the applicant's countable earnings and compare their earnings to an earnings guideline established by the SSA. If the individual does not meet SGA, they have met the initial criteria for being determined "disabled." The LDSS evaluation of SGA will help expedite the SRT process and reduce the number of referrals made to the SRT. SSA SGA guidelines follow:

2010 Monthly Substantial Gainful Activity Amounts	
Non-Blind	**Blind**
$1,000	$1,640

SRT evaluates Steps 2 – 5 to complete the disability determination process. A brief description of SRT's (Steps 2 – 5) evaluation process to determine disability is outlined below:

Step 2: Determine if Claimed Disability is a Severe Impairment

Step 3: Determine if Impairment Meets or Equals Impairment Listings

Step 4: Determine if Applicant is Able to Return to Past Relevant Work

Step 5: Determine if Applicant is Able to Perform Any Other Work

WHEN TO REFER CASES TO SRT

LDSS must refer a case to SRT with an **SRT Referral Packet** when**:**

1. An applicant claims a disability, files an MA application, and does not meet SGA.
2. If SSA has determined an applicant ineligible due to factors other than disability (Examples: overscale income and/or resources)

Note: The LDSS case manager must not deny MA or refuse to forward MA referrals to SRT (and SSA) for any reason related to disability.

WHEN NOT TO REFER CASES TO SRT

LDSS **must not** refer a case to SRT when:

1. An applicant's work earnings exceed SSA SGA guidelines
2. If SSA has determined the applicant is currently disabled, then the disability determination is binding on the State and the LDSS will NOT submit a referral packet to SRT.

FORMS EFFECTIVE 12-1-10

Effective 12/1/2010, LDSS must submit the following forms in order to make a referral for SRT disability determination.

SRT Referral Packet:

- DHR/FIA 700 Customer Declaration of Disability
- DHR/FIA 827 Authorization to Release Information
- DHR/FIA 3368 Disability Report
- OES 06 Substantial Gainful Activity (SGA) Worksheet
- DHR/FIA 707 Disability or Blindness Determination
- Any original medical documentation that the customer provides to the LDSS

SRT will submit the following assessment to the LDSS, as applicable, when the evaluation of the disability determination is complete:

- DHR/FIA 736 Medical, Vocational, and Educational Assessment

An Adverse Notice of Action is sent to the applicant by the LDSS, when applicable:

- DHR/FIA 739 Disability Determination Notice of Action

ACTION REQUIRED:

Refer to: ***Reference Guide*** *– Action Required for ABD Disability Determination: Procedures for Referrals to the State Review Team*

NOTICE:

A grace period of 19 calendar days will be granted to those entities who require additional time to implement the requirements of this AT and Reference Guide. In cases where additional time is required, an effective date of 12/20/10 will be accepted.

INQUIRIES:

For policy questions, contact the DHMH Division of Eligibility Policy at 410-767-1463 or 1-800-492-5231 (select option 2 and request extension 1463).

cc: DHR Executive Staff
DHMH Management Staff
FIA Management Staff
DHR Help Desk
DHMH Executive Staff
DHMH Policy and Training Staff
Constituent Services

ATTACHMENT:

Reference Guide – Action Required for ABD Disability Determination: Procedures for Referrals to the State Review Team

REFERENCE GUIDE

Action Required for ABD Disability Determination: Procedures for Referrals to The State Review Team

REFERENCE GUIDE
Action Required for ABD Disability Determination: Procedures for Referrals to the State Review Team

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DETERMINE IF - APPLICATION, REACTIVATION, OR REDETERMINATION?

I. Review the application for completeness
II. Perform CARES, MMIS, MABS, SVES/SOLQ, and SDX clearances

APPLICATION PROCEDURES

I. If the applicant indicates he or she is disabled and has earned income, the case manager will either mail the customer an application or engage in a face-to-face interview. The case manager will give the applicant the **DHR/FIA 1052** requesting completion of the following forms:

- **OES 06 SGA Worksheet**, including the Impairment-Related Work Expenses descriptions. The applicant is expected to complete the top portion of the SGA Worksheet.
- **DHR/FIA 827** Authorization to Disclose Information Form
- **DHR/FIA 700** Customer Declaration of Disability Form
- **DHR/FIA 3368** Disability Report form is completed **only** when:
  - ✓ The applicant is applying for MA under the X02 category; **OR**
  - ✓ The applicant and/or spouse are receiving any type of income.

II. Once the **OES 06** is returned, the case manager will complete the bottom portion of the SGA Worksheet to compare the earnings to the "non-blind" or "blind" SGA standard.

- If earnings equal or exceed the SGA standard, deny the MA application.
- If earnings are below the SGA standard, the customer must apply for Social Security benefits.

2010 Monthly Substantial Gainful Activity Amounts	
Non-Blind	**Blind**
$1,000	$1,640

III. Follow the appropriate procedure below for applicants who file for disability related Medical Assistance.

A. If no application was filed for SSA, then:
(If the clearances/SVES indicate no application has been filed or the applicant does not provide verification that an application has been filed)

1. Give the applicant the Request for Information to Verify Eligibility Form (DHR/FIA 1052) with instructions to go to SSA to apply for all income benefits that the applicant may be entitled to and:
   a. To return proof that an application for SSA benefits was filed; **OR**
   b. To return proof that an appointment to file an application has been scheduled **AND**,

c. To return proof, within five days of the appointment date, that the appointment has been kept and the application for SSA benefits has been filed.

2. Create a 745 alert to follow up on receipt of proof that the appointment has been kept and that the application for SSA benefits was filed.
3. Deny the MA application on the 30th day when no proof that an SSA application has been filed on SDX, SVES, or SOLQ and:
   a. No verification is received that an application for SSA benefits was filed; **OR**
   b. No verification is received that an appointment to file an application for SSA benefits has been scheduled.
4. Deny the MA application on the 30th day when the SSA appointment was scheduled within 20 days after the MA application date and:
   a. The applicant has not submitted verification that the scheduled appointment was kept; **OR**
   b. There is no verification on SVES, SDX, or SOLQ that an SSA application has been filed.
5. Deny the MA application 10 days after the SSA appointment date when the SSA appointment was scheduled more than 20 days after the MA application date and:
   a. The applicant has not submitted verification that the scheduled appointment was kept; **OR**
   b. There is no verification on SVES, SDX, or SOLQ that an SSA application has been filed.
6. Once the SSA application is verified, if all other eligibility criteria are met, immediately complete and send a referral to SRT, which includes:
   a. DHR/FIA 707;
   b. Verification of SSA status:
      (1) Verification from SSA; **OR**
      (2) Original printout of the appropriate SDX, SVES, and/or SOLQ screen.
   c. Original DHR/FIA 827;
   d. Original DHR/FIA 3368, when required;
   e. Verification of any earned income, if the applicant is employed;
   f. Copy of OES 06 SGA Worksheet, when required;
   g. Any original medical documentation that the customer provides to the LDSS; and
   h. Original DHR/FIA 700.
7. Make sure to set the 745 Alert for all pending applications in order to follow-up at least every 90 days

   Reminder: Remember to use CARES code 566 (Non-Cooperation with Eligibility Process) for all of the above denials.

B. If an application for SSA benefits has been filed and **SSA determined the applicant is currently disabled,** the disability determination is binding on the State and the LDSS will NOT submit a referral packet to SRT. The case manager must then:

1. Review financial eligibility prior to taking action on the case
2. If the applicant is approved for SSDI:
   a. Process the application in the S98 coverage group
   b. Code the UINC screen SA; enter the income amount
      Note: The case could become a spend down
3. If the applicant is eligible for SSI:
   a. Process the application in the S02 coverage group
   b. Code the UINC screen SI; enter the income amount
4. Finalize the application; send the appropriate notice

C. If an application for **SSA benefits has been filed and SSA has denied benefits for <u>non-medical reasons PERTAINING TO NON-COOPERATION</u>** (including, but not limited to, the applicant failed to pursue claim, failed to cooperate, failed or refused to submit to a consultative examination, or did not want to continue development of the claim – see SDX codes on Attachment 3), then:

1. Give the applicant the Request for Information to Verify Eligibility Form (DHR/FIA 1052) with instructions to go to SSA to apply for all benefits that the applicant may be entitled to and:
   a. To return proof that an application for SSA benefits was filed; **OR**
   b. To return proof that an appointment to file an application has been scheduled **AND**,
   c. To return proof, within five days of the appointment date, that the appointment has been kept and the application for SSA benefits has been filed.
2. Create a 745 alert to follow up on receipt of proof that the appointment has been kept and that the application for SSA benefits was filed.
3. Deny the MA application on the 30th day when no proof that an SSA application has been filed on SDX, SVES, or SOLQ and:
   a. No verification is received that an application for SSA benefits was filed; **OR**
   b. No verification is received that an appointment to file an application for SSA benefits has been scheduled.
4. Deny the MA application on the 30th day when the SSA appointment was scheduled **within 20 days** after the MA application date and:
   a. The applicant has not submitted verification that the scheduled appointment was kept; **OR**
   b. There is no verification on SVES, SDX, or SOLQ that an SSA application has been filed.
5. Deny the MA application 10 days after the SSA appointment date when the SSA appointment was scheduled **more than 20 days** after the MA application date and:
   a. The applicant has not submitted verification that the scheduled appointment was kept; **OR**
   b. There is no verification on SVES, SDX, or SOLQ that an SSA application has been filed.
6. Once the SSA application is verified, if all other eligibility criteria are met, immediately complete and send a referral to SRT, which includes:
   a. DHR/FIA 707;
   b. Verification of SSA status:
      (1) Verification from SSA; **OR**
      (2) Original printout of the appropriate SDX, SVES, and/or SOLQ screen.
   c. Original DHR/FIA 827;
   d. Original DHR/FIA 3368, when required;
   e. Verification of any earned income, if the applicant is employed;
   f. Copy of OES 06 SGA Worksheet, when required
   g. Any original medical documentation that the customer provides to the LDSS; and
   h. Original DHR/FIA 700.
7. Make sure to set the 745 Alert for all pending applications in order to follow-up at least every 90 days

D. If an application for SSA benefits has been filed **and SSA has denied benefits for <u>non-medical reasons OTHER than non-cooperation</u>** (see SDX codes on Attachment 2), the case manager must review the applicant's current situation, including income, resources, residency, etc., then:

1. If the applicant's <u>resources exceed</u> the MA program limitation:
   a. Promptly deny the application; and
   b. Do not have the applicant sign the DHR/FIA 827.
2. If the applicant was denied for SSA benefits due to excess income, and if all other eligibility criteria have been met, complete a referral to SRT, which includes the following:
   a. DHR/FIA 707;
   b. Verification of SSA status:
      (1) Verification from SSA; **OR**
      (2) Original printout of the appropriate SDX, SVES, and/or SOLQ screen.
   c. Original DHR/FIA 827;
   d. Original DHR/FIA 3368;
   e. Verification of earned income, if the applicant is employed;
   f. Copy of OES 06 SGA Worksheet, when required;
   g. Any original medical documentation that the customer provides to the LDSS; and
   h. Original DHR/FIA 700.
3. Make sure to set the 745 Alert for all pending applications in order to follow-up at least every 90 days.
4. If the applicant was denied SSA benefits for any <u>other</u> non-medical reason:
   a. Give the applicant the Request for Information to Verify Eligibility Form (DHR/FIA 1052) with instructions to go to SSA to apply for all income benefits that the applicant may be entitled to and:
      (1) To return proof that an application for SSA benefits was filed; **OR**
      (2) To return proof that an appointment to file an application has been scheduled **AND**,
      (3) To return proof, within five days of the appointment date, that the appointment has been kept and the application for SSA benefits has been filed.
   b. Create a 745 alert to follow up on receipt of proof that the appointment has been kept and that the application for SSA benefits was filed.
   c. Deny the MA application on the 30th day when no proof that an SSA application has been filed on SDX, SVES, or SOLQ and:
      (1) No verification is received that an application for SSA benefits was filed; **OR**
      (2) No verification is received that an appointment to file an application for SSA benefits has been scheduled.
   d. Deny the MA application on the 30th day when the SSA appointment was scheduled **within 20 days** after the MA application date and:
      (1) The applicant has not submitted verification that the scheduled appointment was kept; **OR**
      (2) There is no verification on SVES, SDX, or SOLQ that an SSA application has been filed.
   e. Deny the MA application 10 days after the SSA appointment date when the SSA appointment was scheduled **more than 20 days** after the MA application date and:
      (1) The applicant has not submitted verification that the scheduled appointment was kept; **OR**

(2) There is no verification on SVES, SDX, or SOLQ that an SSA application has been filed.

f. Once the SSA application is verified, if all other eligibility criteria are met, immediately complete and send a referral to SRT, which includes:
   (1) DHR/FIA 707;
   (2) Verification of SSA status:
      (a) Verification from SSA; **OR**
      (b) Original printout of the appropriate SDX, SVES, and/or SOLQ screen.
   (3) Original DHR/FIA 827;
   (4) Original DHR/FIA 3368, when required;
   (5) Verification of earned income, if the applicant is employed;
   (6) Copy of OES 06 SGA Worksheet, when required;
   (7) Any original medical documentation that the customer provides to the LDSS; and
   (8) Original DHR/FIA 700.

5. Make sure to set the 745 Alert for all pending applications in order to follow-up at least every 90 days.

E. If an application for SSA benefits has been filed and **SSA has denied benefits for medical reasons before the MA application is acted upon** (see SDX codes on Attachment 1):

AND

1. The application for MA benefits is based on the same medical condition(s) previously considered by SSA, and the applicant indicates on the DHR/FIA 700 that the medical condition(s) has not changed or deteriorated, promptly deny the application. This SSA decision is **binding**, even when the applicant has filed an appeal with SSA.

OR

2. The application for MA benefits is based on a medical condition(s) different from, or in addition to, the medical condition(s) previously considered by SSA, or the applicant indicates on the DHR/FIA 700 that the medical condition(s) has changed or deteriorated, then:
   a. Give the applicant the Request for Information to Verify Eligibility Form (DHR/FIA 1052) with instructions to go to SSA to reapply for all income benefits that the applicant may be entitled to and;
      (1) To return proof that an application for SSA benefits was filed; **OR**
      (2) To return proof that an appointment to file an application has been scheduled **AND**,
      (3) To return proof, within five days of the appointment date, that the appointment has been kept and the application for SSA benefits has been filed.
   b. Create a 745 alert to follow up on receipt of proof that the appointment has been kept and that the application for SSA benefits was filed.
   c. Deny the MA application on the 30th day when no proof that an SSA application has been filed on SDX, SVES, or SOLQ and:
      (1) No verification is received that an application for SSA benefits was filed; **OR**
      (2) No verification is received that an appointment to file an application for SSA benefits has been scheduled.

d. Deny the MA application on the 30th day when the SSA appointment was scheduled **within 20 days** after the MA application date and:
   (1) The applicant has not submitted verification that the scheduled appointment was kept; OR
   (2) There is no verification on SVES, SDX, or SOLQ that an SSA application has been filed.
e. Deny the MA application 10 days after the SSA appointment date when the SSA appointment was scheduled **more than 20 days** after the MA application date and:
   (1) The applicant has not submitted verification that the scheduled appointment was kept; **OR**
   (2) There is no verification on SVES, SDX, or SOLQ that an SSA application has been filed.
f. Once the SSA application is verified, if all other eligibility criteria are met, immediately complete and send a referral to SRT, which includes:
   (1) DHR/FIA 707;
   (2) Verification of SSA status:
      (a) Verification from SSA; **OR**
      (b) Original printout of the appropriate SDX, SVES, and/or SOLQ screen.
   (3) Original DHR/FIA 827;
   (4) Original DHR/FIA 3368, when required;
   (5) Verification of earned income, if the applicant is employed;
   (6) Copy of OES 06 SGA Worksheet, when required;
   (7) Any original medical documentation that the customer provides to the LDSS; and
   (8) Original DHR/FIA 700
g. Make sure to set the 745 Alert for all pending applications in order to follow-up at least every 90 days

F. If an application for SSA benefits has been filed but **SSA has not made a decision,** then:

1. **The case manager must complete and forward a referral to SRT, which includes the following forms and information composing the SRT Referral Packet:**
   a. DHR/FIA 707;
   b. Verification of SSA status:
      (1) Verification from SSA; OR
      (2) Original printout of the appropriate SDX, SVES, and/or SOLQ screen.
   c. Original DHR/FIA 827;
   d. Original DHR/FIA 3368, when required;
   e. Verification of any earned income, if the applicant is employed;
   f. Copy of OES 06 SGA Worksheet, when required;
   g. Any original medical documentation that the customer provides to the LDSS
   h. Original DHR/FIA 700.

   Note: The LDSS must complete the SRT batch sheet daily for referrals to the SRT. The SRT is responsible for signing, dating, and returning the original batch sheets to the respective LDSS offices on a daily basis. (Refer to AT 08-17).

2. **The case remains pending until SRT or SSA provides a disability determination decision.** Make sure to **enter the appropriate delay** code on the MISC screen **for all cases that are pending past 30 days:**
   a. If the information requested from the applicant is not turned in timely, the delay would be considered a customer delay and the case manager must use "Client Delay" Code: **CD**.
   b. If the LDSS failed to refer the case to SRT in a timely manner or the LDSS failed to process the MA case in a timely manner, use "Agency Delay" Code: **AD**.
   c. If the information was provided timely, but a decision has not been received from SRT, review the SRT case notes to determine the reason for delay:
      – If the delay is due to "Awaiting Physician Information" on medical records, use Code: **PE**.
      – If the delay is due to "Awaiting SRT Decision," use Code: **RT**.
      – If the delay is due to the "Client Delay," use Code: **CD**.

   Note: Do not deny cases on CARES to avoid using a delay code.

   Reminder: Make sure to set the 745 Alert for all pending applications in order to follow-up at least every 90 days
3. **If SRT has determined that an applicant is NOT DISABLED then:**
   a. The SRT will send to the LDSS:
      (1) The completed DHR/FIA 707; and
      (2) Two copies of the DHR/FIA 736.
   b. The LDSS must:
      (1) Deny the application and send the appropriate CARES notice
      (2) Use the DHR/FIA 739 as a cover letter
      (3) Send one copy of the DHR/FIA 736 to the applicant or an authorized representative, notifying the applicant that they have been determined not disabled; and
      (4) File the second copy of the DHR/FIA 736 in the case record.
4. **If SRT has determined that an applicant is DISABLED then:**
   a. The SRT shall send the completed DHR/FIA 707 to the LDSS.
   b. The LDSS shall:
      (1) Approve the application if all other eligibility criteria are met; and
      (2) Send the appropriate CARES notice.
5. **Using form DHR/FIA 707, SRT shall notify the LDSS once SSA has made a decision**
   a. When SSA has determined that the applicant is **DISABLED**, the LDSS shall:
      (1) Approve the application, if all other eligibility criteria are met; and
      (2) Send the appropriate CARES notice, but do not send the Disability Determination Notice of Action Form (DHR/FIA 739).
   b. When SSA has determined that the applicant is **NOT DISABLED** (see attached SDX denial codes for medical reasons),the LDSS shall:
      (1) Deny the application according to **COMAR 10.09.24.05-4 C**;
      (2) Send the appropriate CARES notice; do not send the DHR/FIA 739.
   c. When SSA has determined that the applicant failed to cooperate with the disability process (see attached SDX denial codes for non-cooperation),the LDSS shall:
      (1) Deny the application, using code 566 "Non-cooperation with the eligibility process"; and PF13 and **add COMAR 10.09.24.04 N (1)-(4)** to the CARES notice.

G. **Application for emergency medical services for an undocumented or ineligible alien (X02 ABD):**

1. If all other eligibility criteria are met, the case manager must complete a referral to SRT, which includes the following:
   - DHR/FIA 707
   - Original DHR/FIA 827
   - Original DHR/FIA 3368
   - Copy of OES 06 SGA Worksheet, when required
   - Verification of any earned income, if the applicant is employed
   - Any original medical documentation that the customer provides to the LDSS
   - If there is an authorized representative, attach a copy of the AREP screen.
2. Make sure to set the 745 Alert for all pending applications in order to follow-up at least every 30 to 90 days
3. If a decision from SRT determined the undocumented or ineligible alien "disabled," the LDSS must:
   a. Complete form DES 401 or the Emergency Services to Ineligible Aliens form (see Attachment 15)
   b. Attach a copy of the following information:
      (1) MMIS screen 1 or MMIS/CARES screen showing results of Search
      (2) Discharge summary with admission and discharge dates, if applicable
      (3) ER admission, if applicable
      (4) Documentation showing the emergency nature of the medical Services
      (5) SRT determination (if qualifying as disabled/blind)
   d. Send form DES 401 and documentation to the Eligibility Policy Division (address is located on form)
   e. Based on the decision from the Office of Eligibility Services, the LDSS must process the application according to procedures located in Chapter 5 of the MA Manual.

REACTIVATION PROCEDURES

I. <u>The case manager must complete a referral to SRT if all other eligibility criteria have been met</u>. The case manager must indicate on the DHR/FIA 707 the date that all information (needed to determine MA eligibility) was finally received. This information must be narrated in CARES. The SRT referral must include forms listed on page 3 of the Action Transmittal.

Reminder: Failure to send a notice when partial information is returned is an appeal issue. The case manager must send a notice to the customer and narrate in CARES whenever partial information is returned.

A. When the decision is received from SRT, the case manager will:

1. Pend the MA application in CARES using the original application date.
2. Perform CARES, MMIS, MABS, SVES/SOLQ AND SDX clearances.
3. Review all the clearances to verify there has been no change in the applicant's circumstances.

B. If the SRT has determined that an applicant is **NOT DISABLED**, the case manager shall:

1. Deny the application and send the appropriate CARES notice

2. Use the DHR/FIA 739 as a cover letter and send one copy of the DHR/FIA 736 to the applicant or an authorized representative, notifying the applicant that they have been determined not disabled; and
3. File the second copy of the DHR/FIA 736 in the case record.

C. If the SRT has determined that an applicant is **DISABLED**, the case manager shall:

1. Approve the application, if all other eligibility criteria are met; and
2. Send the appropriate CARES notice.

REDETERMINATION PROCEDURES

I. MA ABD Coverage Groups

A. At redetermination, no new SRT referrals are needed because MA continues as long as the recipient is continuing the application and/or appeal process with SSA. The MA case remains open until a **final binding** SSA decision is made. An eligibility determination for all factors of eligibility other than disability is all that is required to continue MA. At redetermination, the LDSS should use the SDX, SVES, or SOLQ to determine the recipient's SSA benefits status. If unable to determine by SDX, SVES or SOLQ clearances, the LDSS must obtain verification from the recipient.

B. Follow these procedures based on the recipient's circumstances:

1. If the recipient does not have a pending application for SSA, refer the recipient to SSA via the DHR/FIA 1052. No verification of SSA appointment or interview is received, close the MA case with code 566 (Non-Cooperation with Eligibility Process) and notify the recipient that he or she is no longer eligible for MA.
2. If the recipient has applied for SSA benefits and SSA has not made a final decision regarding the recipient's disability, then the case manager shall recertify MA eligibility if all other eligibility factors are met, and create a 745 alert to follow up periodically on the status of the SSA application.
3. <u>If SSA determines that the recipient is disabled, then the case manager must review financial eligibility prior to taking action on the case:</u>
   a. <u>If the recipient was approved for SSDI, the income is entered and the case could become a spend down.</u>
   b. <u>If the recipient is eligible for SSI, the case manager must close the case and open as an S02 coverage according to SSA's eligibility date.</u>
4. If SSA determines that the recipient is not disabled, the case manager must close the MA case and notify the recipient that he or she is no longer eligible for MA. When closing the case, select PF13 from the MAFI screen and add the following text to the closing notice: "If you submit verification that you filed an appeal with the Social Security Administration (SSA) within 10 days of the date of this notice, your Medical Assistance benefits may be reopened pending the outcome of the appeal."
5. If SSA denies an applicant for a non-medical reason other than non-cooperation, the case manager must refer the recipient to the SRT for a disability determination.

C. For recipients, an SSA **final binding** decision exists when:

1. SSA has made a decision and the decision **has not** been appealed; or
2. SSA has made a decision and all of the following SSA appeal levels have been exhausted:

a. SSA Reconsideration
b. SSA Administrative Law Judge hearing
c. SSA Appeals Council review

D. Generally the time for filing an appeal of an SSA decision is 60 days from the date of the decision. However, SSA allows, in some circumstances, late appeals for good cause.

II. X02 Coverage Group

When the SRT disability decision period has ended or upon redetermination, the case manager must send another referral packet to SRT. If SRT determines that the recipient remains disabled, then send the DES 401 Emergency Services to Ineligible Aliens Form, the supporting medical documentation, and a copy of the original DHR/FIA 707 Form to OES for a medical decision to be made. If SRT determines that the recipient is no longer disabled, do not send any documentation to OES, **but close the case.**

IMPORTANT REMINDERS FOR CASE MANAGERS:

1. As a condition of eligibility for MA, unless good cause for not doing so is shown, applicants must take all the necessary steps to obtain and accept all income benefits to which they may be entitled, such as any annuities, pensions, retirement, and disability benefits including, but not limited to:
   - Veterans' compensation and pensions
   - Social Security Administration (SSA) benefits (other than SSI)
   - Railroad retirement benefits
   - Unemployment compensation
2. Each LDSS is responsible for completing the SRT Referral Batch Sheet on a daily basis (see Attachment 6).
3. Keep a copy of all forms in the case record.
4. Use CARES code 566 (Non-Cooperation with Eligibility Process) for all denials with SDX codes shown on Attachment 3.
5. Send a notice to the customer and narrate in CARES whenever a customer does not provide all requested information.
6. When counting days pending, Day One is the application date.
7. Make sure to enter the appropriate delay code on the MISC screen for all cases that are pending past 30 days. If the information requested from the applicant is not turned in timely, the delay would be considered a Customer Delay. Use Code: **CD**. If the LDSS failed to refer the case to SRT in a timely manner or the LDSS failed to process the MA case in a timely manner, use "Agency Delay" Code: **AD.** If the information was provided timely, but a decision has not been received from SRT, review SRT case notes to determine the reason for the delay. If the delay is due to "awaiting physician information" on medical records, use Code: **PE**. If the delay is due to "awaiting SRT decision," use Code: **RT**. (Do not deny cases on CARES to avoid using a delay code).
8. Only SSA and SRT can make disability determinations. The LDSS cannot make medical disability determinations, including presumptive disability determinations.

ATTACHMENTS:

1. SDX denial codes for medical reasons
2. SDX denial codes for non-medical reasons
3. SDX denial codes for non-cooperation
4. SDX appeal decision codes
5. Disability determination process flowchart
6. DHR/FIA 210 SRT Referral Batch Sheet
7. DHR/FIA 700 Customer Declaration of Disability
8. DHR/FIA 1052 Request for Information to Verify Eligibility
9. OES 06 Substantial Gainful Activity (SGA) Worksheet
10. DHR/FIA 707 Disability or Blindness Determination
11. DHR/FIA 3368 Disability Report
12. DHR/FIA 827 Authorization to Release Information
13. DHR/FIA 739 Disability Determination Notice of Action
14. DHR/FIA 736 Medical, Vocational, and Educational Assessment
15. DES 401 Emergency Services to Ineligible Aliens

SDX Denial Codes
Medical Reasons

N07: Cessation of recipient's disability
N08: Cessation of recipient's blindness
N15: Blind claim denied. Applicant not blind
N16: Disability claim denied. Applicant not blind
N27: Disability terminated due to SGA
N30: Slight Impairment - medical consideration alone, no visual impairment.
N31: Capacity for SGA - customary past work, no visual impairment.
N32: Capacity for SGA - other work, no visual impairment.
N33: Engaging in SGA despite impairment, no visual impairment.
N34: Impairment is no longer severe at the time of decision and did not last twelve months. No visual impairment.
N35: Impairment is severe at the time of adjudication and did not last twelve months, no visual impairment.
N40: Impairment(s) does not meet or equal listing (disabled child under eighteen only), no visual impairment.
N41: Slight impairment - medical condition alone, visual impairment or blindness.
N42: Capacity for SGA - customary work, visual impairment.
N43: Capacity for SGA - other work, visual impairment.
N44: Engaging in SGA despite impairment, visual impairment.
N45: Impairment no longer severe at the time of adjudication and did not last twelve months, visual impairment.
N46: Impairment is severe at time of adjudication but not expected to last twelve months, visual impairment.
N51: Impairment(s) does not meet or equal listing (disabled child under eighteen only), visual impairment.
N55: Impairment due to DAA (no visual impairment)
N56: Impairment due to DAA (visual impairment)

SDX Denial Codes
Non-Medical Reasons

N01: Recipient's countable income exceeds Title XVI payment amount and his/her State's payment standard
***N02:** Recipient is inmate of public institution
***N03:** Recipient is outside of U.S.
***N04:** Recipient's non-excludable resources exceed Title XVI limitations
***N05:** Unable to determine if eligibility exists for some month(s) of a period of nonpayment
N12: Recipient voluntarily withdrew from SSI program
N13: Not a U.S. citizen or eligible alien
N14: Aged claim denied for age
N19: Recipient has voluntarily terminated participation in the SSI program
***N22:** Inmate of a penal institution
***N23:** Not a U.S. Resident
N24: Convicted of felony of fraudulently misrepresenting residence in two or more States
N25: Claimant is fleeing to avoid prosecution for, or custody or confinement after conviction for a crime which is a felony (or in New Jersey, a high misdemeanor) under the laws of the place from which he/she flees, or is violating a condition of probation or parole imposed under Federal or State law.
N52: Deleted from the State rolls before January 1973 payment.
N53: Deleted from State rolls after January 1973 payment.
N54: DO unable to locate applicant.

*** May be returned to LDSS by SRT to review and take further action.**

SDX Denial Codes
Non-Cooperation

N06: Recipient failed to file for other benefits
N09: Recipient refused vocational rehabilitation without good cause
N10: Recipient refused treatment for drug addiction
N11: Recipient refused treatment alcoholism
N17: Failure to pursue claim by the applicant
N18: Failed to cooperate on developing of claim
N20: Recipient failed to furnish required evidence
N37: Failure or refusal to submit to consultative examination, no visual impairment.
N38: Applicant does not want to continue development of claim, no visual impairment.
N39: Applicant willfully fails to follow prescribed treatment, no visual impairment.
N36: Insufficient, or no medical data furnished, no visual impairment.
N47: Insufficient, or no, medical evidence furnished, visual impairment.
N48: Failure, or refusal, to submit to consultative examination, visual impairment.
N49: Applicant does not want to continue development of claim, visual impairment.
N50: Applicant willfully fails to follow prescribed treatment, visual impairment.

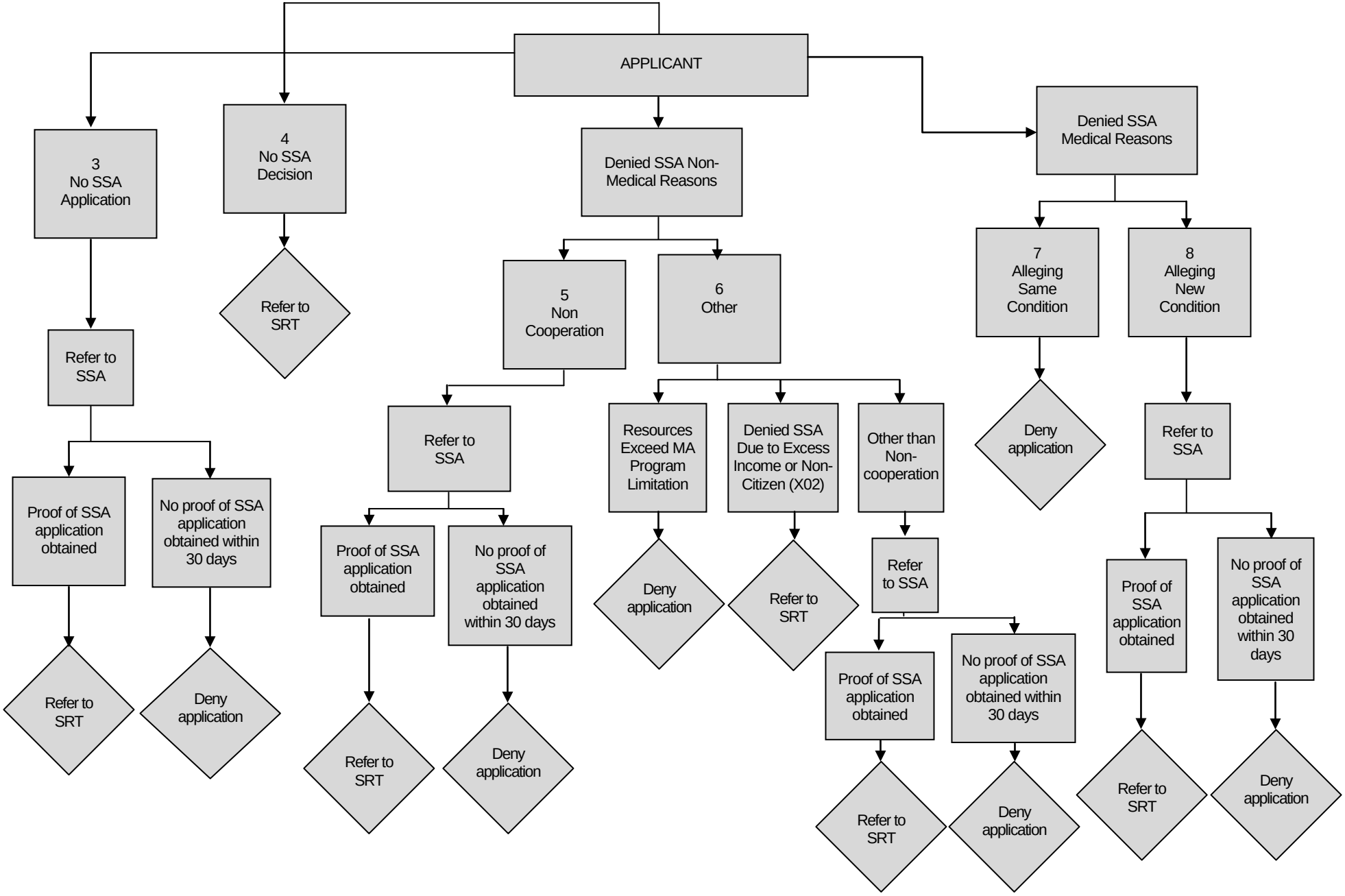
SDX Codes
Appeals Decision

AD Dismissed/Abandoned
FA Favorable/Appeal Approved
FC Fully/Partially Favorable (converted records only)
FF Fully Favorable
FN Favorable/SSA not appealed (court cases only)
OT Closed: Other
PF Partially Favorable
T1 Dismissed: Claimant Deceased
UA Unfavorable/appealed by recipient (court case only)
UF Unfavorable
UN Unfavorable/not appealed by recipient (court case only)
WC Dismissed/Withdrawn (converted records only)
WD Dismissed: Withdrawn
1D Dismissed: Cannot be appealed
2D Dismissed: Filed by improper requestor
3D Dismissed: Filed late without good cause
4D Dismissed: Withdrawn

*** If you have questions regarding an appeal decision please call The Social Security Administration at 1-800-772-1213. The SSA liaison contact AT was obsolete with the elimination of the DEAP.**

Attachment 5

Disability Determination Process



Attachment 6

STATE REVIEW TEAM REFERRAL BATCH SHEET

LDSS Office Name_____ Page_____ of _____

Print LDSS Office Name**. Do NOT list the LDSS District office number**

_____/_____/_____ _____ LDSS Staff

Date Submitted to SRT **LDSS Staff Name First Last (Print)** **Telephone Number: (_____)_____-_____**

_____/_____/_____ _____

Date Received in SRT **SRT Staff Name First/Last (Print)**

CUSTOMER NAME (PRINT)	SOCIAL SECURITY NUMBER	CLIENT ASSISTANCE UNIT NUMBER	SRT USE ONLY REFERRAL INCLUDED	
			YES	NO

_____/_____/_____ _____

Date Returned to LDSS **SRT Staff Name First /Last (Print)**

SRT Staff telephone number:_____

DHR/FIA 210 (10/10)

STATE REVIEW TEAM REFERRAL BATCH SHEET INSTRUCTIONS

Local Department of Social Services

1. LDSS Office Name: **Print** the name of the local department office.
   - Examples: Montgomery County – Rockville
     Prince George's County – Hyattsville
     Hilton Heights
2. Page __ of __: List number of pages submitted
   - Examples: Page 1 of 1
     Page 2 of 3
3. Date Submitted to SRT: List the Month/Day/Year of the day the referrals are being sent to the SRT.
4. LDSS staff name: **Print** the name of the LDSS staff responsible for completing the form LDSS staff telephone number: The direct telephone number for the LDSS contact person regarding referrals listed on the completed form.
5. Print the customer's name (First then last name) for each referral sent with the completed SRT referral batch sheet form. (Check to ensure the correct spelling is provided for each customer listed.
6. List the social security number (SSN) for each customer listed. If the customer does not have a SSN write the word **None** in the column for SSN.
7. Client Assistance Unit Number: List the customer's AU number for the application period the disability determination is required.

Note: Complete all information on each page. (Including LDSS office name, date submitted to SRT, LDSS staff name and telephone number). Each listed case must include the appropriate 9-digit AU number.

State Review Team

1. Date Received in SRT: List the Month/Day/Year the SRT referral batch sheet and referrals are received by SRT.
2. SRT staff name: Print the first and last name of the SRT staff verifying the information and receipt of the referral packets listed on the batch sheet.
3. Referral Received (YES/NO): Place an X in the appropriate column to indicate if the referral whether the listed referral was received.
4. Date Returned to LDSS: List the Month/Day/Year the batch sheet is returned to the LDSS office.
5. Make a copy of the batch sheet after notating whether each referral listed on the batch sheet was received.
6. File the copy of the batch sheet in the assigned binder.
7. Return the original batch sheet to the LDSS.

Note: SRT staff will check for receipt of all referrals listed on the batch sheet received from the local department. SRT will contact the LDSS regarding any discrepancies.

Attachment 7

CUSTOMER DECLARATION OF DISABILITY FORM

LOCAL DEPARTMENT USE ONLY
AU#
CLIENT ID#

Please complete all sections (front and back) of this form and sign where indicated. If you need help completing this form, please contact your case manager at: _____ and have the form with you when you call. You **must** return the completed form to the person and address below.

Case Manager Name _____

First **Last**

Local Department Address _____

_____

City **State** **Zip Code**

If the person completing this form is someone other than the disabled person, please complete the following information:

Name _____

Relationship to Disabled Person _____

Daytime Phone Number _____

Address _____

_____

City **State** **Zip Code**

SIGN HERE _____ **DATE** _____

YOUR SIGNATURE

TO BE COMPLETED BY THE DISABLED PERSON:

Name _____
Last **First**

Social Security Number _____ **Date of Birth** _____

Address _____

_____
City **State** **Zip Code**

1. Has there been any change (for better or worse) in your illnesses, injuries, or conditions since **you last applied for Social Security disability benefits?** ☐Yes ☐No
If **"Yes"**, please describe in detail:

_____
_____
_____

Approximate date the changes occurred		
MONTH	**DAY**	**YEAR**

2. Do you have any new physical or mental limitations as a result of your illnesses, injuries or conditions **since you last applied for Social Security disability benefits?** ☐Yes ☐No
If **"Yes"**, please describe in detail:

_____
_____
_____

Approximate date the changes occurred		
MONTH	**DAY**	**YEAR**

3. Do you have any new illnesses, injuries or conditions **since you last applied for Social Security disability benefits?** ☐Yes ☐No
If **"Yes"**, please describe in detail:

_____
_____
_____

Approximate date the changes occurred		
MONTH	**DAY**	**YEAR**

SIGN HERE _____ **DATE** _____
YOUR SIGNATURE

LOCAL DEPARTMENT OF SOCIAL SERVICES

INSTRUCTIONS

The Local Department Case Manager must:

- Complete the information at the top of page 1;
- Give or mail the form to the applicant for completion; and
- Include the completed form with all SRT referral packets.

NOTE: All individuals applying for Medical Assistance based on being Blind or Disabled must complete and return the Customer Declaration of Disability form.

MARYLAND DEPARTMENT OF HUMAN RESOURCES
FAMILY INVESTMENT ADMINISTRATION
REQUEST FOR INFORMATION TO VERIFY ELIGIBILITY

1. LOCAL DEPARTMENT	2. DATE
	3. CASE NAME
	4. CATEGORY & AU NUMBER
	5. CASE MANAGER
	6. TELEPHONE NUMBER

DEAR APPLICANT/RECIPIENT:

To get benefits you must give us the proofs **MARKED BELOW** for you and **ALL PERSONS FOR WHOM YOU ARE APPLYING**. If you have any questions or need help to get the proofs, please call me. Thank you.

☐ Bring the proofs to an interview…
☐ Bring or send them to me no later than…

DATE:

	PROOF OF INCOME		**PROOF OF IDENTITY**		**MOST RECENT PROOF OF EXPENSES BILLED OR PAID BY YOU OR OTHERS FOR YOUR HOUSEHOLD**
	Pay stubs – last _____		Social Security Cards		Heat, Lights, Telephone, Water, Sewage, Trash Removal, Other Utilities
	Statement on Employer's Letterhead		Birth or Baptismal Certificates		*Rent Mortgage Receipts
	Tax Return 20_____		Drivers Licenses		*Amount of Shared Expenses
	Unemployment Benefits		Alien Registrations		*Child or Adult Dependent Care
	Union/Strike Benefits		Marriage License/Divorce Decree		Property Taxes/Homeowners Insurance
	Child Support or Alimony				Medical Bills
	Social Security Benefits				
	SSI/SSDI Benefits				
	Veteran's Benefits or Other Pensions		PROOF OF ASSETS		OTHER PROOFS
	Education Loans/Grants/Scholarships		Checking and Savings Accounts		School Attendance and Financial Aid Form 604 or 690
	Military Allotments		Certificates of Deposit (CD's, IRA's and Keogh Accounts)		Address of Absent Parents
	*Payments From Others for Expenses		Stocks, Bonds, Mutual Funds		Pregnancy/Prenatal Care
	*Contributions Received		Dividends and Interest		Disability Incapacitation
	*From Roomers or Boarders		Life and Health Insurance		Application for Other Benefits
	Rental/Mortgage Income		Cars and Other Vehicle Loans		Proof of Who Lives With You
	Self Employment Tax Records		Make, Model and Year for all Cars, Trucks, & Other Licensed Vehicles		Report Cards
	Workman's Compensation		Transferred Assets in Last 3 Months		Health Care Forms
	Wage Form		Property: House, Land, Other		Type of Housing

***IMPORTANT**: These proofs must include the name, address and telephone numbers of the persons making the statement.

OTHER INSTRUCTIONS with Box Reference Number:

SUBSTANTIAL GAINFUL ACTIVITY WORKSHEET

Name of Disabled Person: _____ **Social Security Number:** _____

Disability: ☐ Blindness ☐ Other

1. **Gross** Earned Income (Please attach verification) $ _____ per month

2. **Employer Subsidy** (if any) included in your pay (e.g., some employers employ disabled persons and subsidize their wages by paying them the same wages as a nondisabled employee though they may be performing less strenuous work, or working less hours) $ _____ per month

3. **Impairment-Related Work Expenses** per month (see attached for description)
   - a. Attendant Care Services $ _____
   - b. Transportation Costs _____
   - c. Medical Devices _____
   - d. Work-Related Equipment _____
   - e. Prosthesis _____
   - f. Residential Modifications _____
   - g. Routine Drugs and Routine Medical Services _____
   - h. Diagnostic Procedures _____
   - i. Nonmedical Applications and Devices _____
   - j. Assistants (e.g., if visually impaired, cost to hire reader) _____
   - k. Other Items and Services _____

++

Office Use only (Case Manager complete below)

4. **TOTAL Impairment-Related Work Expenses**

   Add together all that apply (total of 3a through 3k) $ _____ per month

5. **Net Countable Earnings** (from 1 subtract 2 and 4) $ _____ per month

- Are current countable earnings (line 5) greater than
  - Blind SGA Amount $ 1,640 ? _____ Yes _____ No
  - Non Blind SGA Amount $ 1,000 ? _____ Yes _____ No

  (2010 SGA amounts)
- If the answer is No, the customer must apply for Social Security benefits
- If the answer is Yes, the client is engaging in SGA. Deny the MA application.

_____ _____ _____

Case Manager Signature | Telephone Number | Date

Address: _____

SUBSTANTIAL GAINFUL ACTIVITY

The law requires that we deduct the cost of certain items and services the disabled person needs in order to work. The cost can be deducted from earnings in SGA determinations even though the items and services are also used for non-work activities.

The amount of Impairment-Related Work Expenses that may be deducted is subject to reasonable limits. Deductions for needed items and services will be made only if the cost is paid by the impaired individual, not by and insurance company, social agency, or other reimbursement.

Example of Impairment-Related Work Expenses

Attendant Care Services:

This includes forms of personal assistance to help an individual meet his or her essential needs at home or at work. Personal assistance includes: bathing, dressing, cooking, eating, communicating and traveling to and from work.

Transportation Costs:

A disabled person may have deductible transportation costs if he or she requires structural or operational modifications to a vehicle in order to drive, or be driven, to work.

The cost of the automobile is not deductible, but if paid by the disabled person, the modifications are. If an agency pays for the modification, then the cost cannot be deducted.

A disabled person might also need to pay for a taxi or pay for an independent driver, and this can be written off because of their inability to use available public transportation.

Medical Devices:

This includes durable medical equipment which can withstand repeated use and is primarily used to serve a medical purpose. These items are generally not useful to a person in the absence of an illness or injury. Examples of medical devices include: wheelchairs, respirators, pacemakers, leg/arm/back braces and similar items.

Work Related Equipment:

This includes equipment which is impairment-related and necessary for the impaired individual to do his or her job. Examples include: vision and sensory aids for the blind and telecommunications devices for the deaf.

Prostheses:

Items included in this category are devices used to replace internal body organs or external body parts. For example: artificial hips, limbs or other body parts. If the replacement is purely cosmetic, the cost is usually not deductible.

Residential Modifications:

This category includes changes made to alter the physical structure or operation of a person's home in order to accommodate his or her functional limitations.

If the person works **away** from their home, modifications which permit access to the street, such as a ramp or hand rails, are deductible.

If the individual works **at home**, the costs to modify the interior of the home in order to create a working space compatible to the person's impairment would be deductible to the extent that the modifications pertain specifically to the work space. An example of this would be the enlargement of a doorway leading into an office.

Routine Drugs and Services:

Routine drugs and medical services are deductible if they are needed to control the disability, thus permitting the person to work.

Other Costs:

Similar items or services may also be deductible if they meet the criteria listed above. Examples include:

- Expendable medical supplies such as ace bandages, elastic stockings and face masks.
- Expenses relating to a seeing-eye dog. These expenses may include the purchasing of dog food, licenses and veterinary services.

It is important to remember that if the costs of equipment or home modifications can be deducted by a self-employed individual on their tax return as a business expense, that same cost is not deductible as Impairment-Related Work Expenses.

☐ ABD
☐ X02

☐ Initial Application
☐ Reactivation
☐ Remand as a result of an Appeal

DISABILITY OR BLINDNESS DETERMINATION TRANSMITTAL

PRINT ONLY **Date Referred** _____

I. Client Name: _____
Last First MI

LDSS: _____

District: _____

Social Security #: _____ Case Manager: _____

Client ID #: _____ Telephone #: _____

_____
Application Date

Currently employed: Yes _____ See Attached Earnings Documentation
No _____

_____
Date Required Information was received from the Customer/Representative

---

II. MEDICAL DETERMINATION **ONSET DATE** _____

☐ No Medically Determinable Impairment (**Not Disabled**)
☐ Impairment(s) Not Severe (**Not Disabled**)
☐ Impairment(s) Severe by Not Expected to Last 12 Months (**Not Disabled**)
☐ Meets Listing _____ (cite listing) (**Disabled**)
☐ Equals Listing _____ (cite listing) (**Disabled**)
☐ Impairment(s) Severe by Doesn't Meet or Equal Listing (**See Section III**)
☐ Medical Evidence Needed (Specify in comment section)

COMMENTS: _____

Signatures: MRT OPHTHALMOLOGIST _____ DATE _____
MRT PHYSICIAN _____ DATE _____
MRT PSYCHOLOGIST/PSYCHIATRIST _____ DATE _____

III. MEDICAL VOCATIONAL DETERMINATION

☐ Can Still do Past Relevant Work (**Not Disabled**)
☐ Cannot Make an Adjustment to do Other Work (**Disabled**)

COMMENTS:

Signature: DISABILITY SPECIALIST _____ DATE _____

DHR/FIA 707 (revised 1/09) *Previous editions obsolete*.

WHITE – State Review Team Copy PINK – LDSS Case Record YELLOW – LDSS Control Copy

INSTRUCTIONS FOR FORM DHR/FIA 707

Transmittal for State Review Team

SECTION I

ABD/X02: Place a check (✓) to identify the type of case

Initial Application/Reactivation/Remand as a result of an Appeal: Place a check (✓) in the appropriate box to identify the type of information submitted.

Date Referred: Indicate the date the referral is forwarded to the State Review Team.

Client's Name: **Print Only**.

Social Security Number: Enter the client's Social Security Number.

Client ID: Enter Customer's Client ID.

LDSS/District: Enter the appropriate Local Department Name and District Office Number.
(**Do Not Abbreviate**)

Case Manager/Telephone: Indicate the case manager's first and last name assigned to the case and the corresponding telephone number. (**Do Not Abbreviate**)

Application Date: Date of Initial Application.
Date Required Information was received: Date **all** required information was received by the local department from the Customer/Representative

Currently Employed: Check yes or no. If yes, attach the appropriate earnings verification (Refer to the Medical Assistance policy manual)

SECTION II

THIS SECTION IS FOR DISABILITY REVIEW TEAM USE ONLY

ONSET DATE: For the purpose of the Medical Assistance disability determination, this date represents the earliest date the individual's medical condition met the definition of disabled based on the medical evidence obtained.

SECTION III

THIS SECTION IS FOR REVIEW TEAM USE ONLY

FORMS DISTRIBUTION: 1 copy – State Review Team (White)
1 copy – Local Department Case Record (Pink)
1 copy – LDSS Control Copy (Yellow)

DISABILITY REPORT – Form DHR/FIA – 3368
COMPLETING THIS FORM

THIS IS NOT AN APPLICATION

HOW TO COMPLETE THIS FORM

The information that you give us on this form will be used by the office that makes the disability determination.

- Please fill out as much of this form as you can.
- Print clearly.
- **DO NOT LEAVE ANSWERS BLANK.** If you do not know the answer, or the answer is "none" or "does not apply," please write: "don't know" or "none" or "does not apply."
- **IN SECTION 4, PUT INFORMATION FOR ONLY ONE DOCTOR/THERAPIST/HOSPITAL/CLINIC IN EACH SPACE.**
- Each address should include a ZIP code. Each telephone number should include an area code.
- When a question refers to "you," "your" or the "Disabled Person," it refers to the person who is applying for Medical Assistance benefits. If you are filling out the form for someone else, please provide information about him or her.
- Be sure to explain an answer if the question asks for an explanation, or if you want to give additional information.
- If you need more space to answer any questions or want to tell us more about an answer, please use the "REMARKS" section on Page 9 and show the number of the question being answered.

ABOUT YOUR MEDICAL RECORDS

If you have any medical records and copies of prescriptions at home for the person who is applying for Medical Assistance benefits, send them to our office with your completed forms or bring them with you to your interview.

YOU DO NOT NEED TO ASK DOCTORS OR HOSPITALS FOR ANY MEDICAL RECORDS THAT YOU DO NOT ALREADY HAVE. With your permission we will do that for you. The information we ask for on this form tells us to whom we should send a request for medical and other records. If you cannot remember the names and addresses of any of the doctors or hospitals, or the dates of treatment, perhaps you can get this information from the telephone book, or from medical bills, prescriptions and prescription bottles.

If you need the records back, tell us and we will photocopy them and return them to you.

DISABILITY REPORT

For Local Department and State Review Team use Only
Do not write in this box.

Client ID# _____

Medical Assistance AU# _____

SECTION 1 – INFORMATION ABOUT THE DISABLED PERSON

A. **NAME** (First, Middle Initial, Last)

B. **SOCIAL SECURITY NUMBER**

C. **DAYTIME TELEPHONE NUMBER** *(If you have no number where you can be reached, give us a daytime number where we can leave a message for you.)*

_____ _____ (Your Number (Message Number
Area Code Number

D. Give 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 with your application.

NAME _____ RELATIONSHIP _____

ADDRESS _____
(Number, Street, Apt. No. (If any), P.O. Box, or Rural Route)

_____ _____ _____ DAYTIME PHONE _____ _____
City State Zip Area Code Number

E. What is your **height** without shoes? _____ feet _____ inches

F. What is your **weight** without shoes? _____ pounds

G. Have you applied for Social Security benefits? ☐ NO ☐ YES If **YES** when:

MONTH	DAY	YEAR

H. Can you **speak and understand English?** ☐ YES ☐ NO

If you cannot **speak and understand English**, is there someone we may contact who speaks and understands English and will give you messages? ☐ YES ☐ NO (If "YES", and that person is the same as in "D" above write "SAME" here: _____ . If not, complete the following information.)

NAME _____ **RELATIONSHIP** _____

ADDRESS _____
(Number, Street, Apt. No. (If any), P.O. Box, or Rural Route)

_____ _____ _____ **DAYTIME PHONE** _____ _____
City State Zip Area Code Number

I. Can you **read and understand English?** ☐ YES ☐ NO

J. Can you **write more than your name in English?** ☐ YES ☐ NO

K. Can you Speak English? ☐ YES ☐ NO

SECTION 2
YOUR ILLNESSES, INJURIES OR CONDITIONS AND HOW THEY AFFECT YOU

A. What are the illnesses, injuries or conditions that limit your ability to work?

B. How do your illnesses, injuries or conditions limit your ability to work?

C. Do your illnesses, injuries or conditions cause you **pain** or **other symptoms**? ☐ YES ☐ NO

D. When did your illnesses, injuries or conditions **first interfere with your ability to work?**

MONTH	DAY	YEAR

E. When did you become **unable to work** because of your illnesses, injuries or conditions?

MONTH	DAY	YEAR

F. Have you **ever worked**? ☐ YES ☐ NO (If "NO," go to Section 4.)

G. Did you **work at any time** after the date of your illnesses injuries or conditions first interfered with your ability to work? ☐ YES ☐ NO

H. If "YES", did your illnesses, injuries or conditions cause you to: *(check all that apply)*

☐ **work fewer hours?** *(Explain below)*
☐ **change your job duties?** *(Explain below)*
☐ **make any job-related changes such as your attendance, help needed, or employers?** *(Explain below)*

I. Are you **working now**? ☐ YES ☐ NO

If "NO," when did you stop working?

MONTH	DAY	YEAR

J. Why did you stop working?

SECTION 3 – INFORMATION ABOUT YOUR WORK

A. List all the jobs that you had in the 15 years before you became unable to work because of your illnesses, injuries or conditions.

JOB TITLE (Example: Cook)	TYPE OF BUSINESS (Example: Restaurant)	DATES WORKED (month & year)		HOURS PER DAY	DAYS PER WEEK	RATE OF PAY (per hour, day, week, month or year)	
		From	To				
						$	
						$	
						$	
						$	
						$	
						$	
						$	

B. Which job did you do the longest? _____

C. Describe this job. What did you do all day? (If you need more space, write in the "Remarks" section.)

_____

_____

D. In **this job**, did you:

Use machines, tools or equipment? ☐ YES ☐ NO

Use technical knowledge or skills? ☐ YES ☐ NO

Do any writing, complete reports, or perform duties like this? ☐ YES ☐ NO

E. In **this job**, how many total hours each day did you:

Walk? _____ Stoop? *(Bend down & forward at waist.)* _____ Handle, grab or grasp big objects? _____

Stand? _____ Kneel? *(Bend legs to rest on knees.)* _____ Reach? _____

Sit? _____ Crouch? *(Bend legs & down & forward.)* _____ Write, type or handle small objects? _____

Climb? _____ Crawl? *(Move on Hands & knees.)* _____

F. Lifting and Carrying *(Explain what you lifted, how far you carried it, and how often you did this.)*

_____

_____

G. Check **heaviest** weight lifted:

☐ Less than 10 lbs ☐ 10 lbs ☐ 20 lbs ☐ 50 lbs ☐ 100 lbs or more ☐ Other _____

H. Check weight **often** lifted:

☐ Less than 10 lbs ☐ 10 lbs ☐ 25 lbs ☐ 50 lbs or more ☐ Other _____

I. Did you supervise other people in this job? ☐ YES *(Complete items below.)* ☐ NO *(If No, go to J.)*

How many people did you supervise? _____

What part of your time was spent supervising people? _____

Did you hire and fire employees? ☐ YES ☐ NO

J. Were you a lead worker? ☐ YES ☐ NO

SECTION 4 – INFORMATION ABOUT YOUR MEDICAL RECORDS

A. Have you been seen by a **doctor/hospital/clinic** or anyone else for the illnesses, injuries or conditions that limit your ability to work? ☐ YES ☐ NO

B. Have you been seen by a **doctor/hospital/clinic** or anyone else for emotional or mental problems that limit your ability to work? ☐ YES ☐ NO

If you answered "NO" to both of these questions, go to Section 5

C. List other names you have used on your medical records. _____

Tell us who may have medical records or other information about your illnesses, injuries or conditions.

D. **List each DOCTOR/HMO/THERAPIST/OTHER.** Include your **next appointment**.

1.

NAME			DATES
STREET ADDRESS			**FIRST** VISIT
CITY	**STATE**	**ZIP**	**LAST** SEEN
PHONE (Area Code) (Phone Number)		**PATIENT ID #** (if known)	NEXT **APPOINTMENT**
REASON FOR VISITS			
WHAT **TREATMENT** WAS RECEIVED?			

2.

NAME			DATES
STREET ADDRESS			**FIRST** VISIT
CITY	**STATE**	**ZIP**	**LAST** SEEN
PHONE (Area Code) (Phone Number)		**PATIENT ID #** (if known)	NEXT **APPOINTMENT**
REASON FOR VISITS			
WHAT **TREATMENT** WAS RECEIVED?			

DOCTOR/HMO/THERAPIST/OTHER

SECTION 4 – INFORMATION ABOUT YOUR MEDICAL RECORDS

3.

NAME			DATES
STREET ADDRESS			**FIRST** VISIT
CITY	**STATE**	**ZIP**	**LAST** SEEN
PHONE Area Code / Phone Number		**PATIENT ID #** (if known)	NEXT **APPOINTMENT**
REASON FOR VISITS			
WHAT **TREATMENT** WAS RECEIVED?			

If you need more space, use Section 9

E. **List each HOSPITAL/CLINIC. Include your next appointment.**

1.

HOSPITAL/CLINIC			TYPE OF VISIT	DATES	
NAME			☐ INPATIENT STAYS (Stayed at least overnight)	DATE IN	DATE OUT
STREET ADDRESS					
				DATE FIRST VISIT	DATE LAST VISIT
CITY	STATE	ZIP	☐ OUTPATIENT VISITS (Sent home same day)		
				DATE OF VISITS	
PHONE Area Code / Phone Number			☐ EMERGENCY ROOM VISITS		

Next **appointment** _____

Reasons for visits _____

What **treatment** did you receive? _____

What **doctors** do you see at this hospital/clinic on a regular basis? _____

SECTION 4 – INFORMATION ABOUT YOUR MEDICAL RECORDS
List any Hospital/Clinic that may have your medical records

HOSPITAL/CLINIC

1.

HOSPITAL/CLINIC			TYPE OF VISIT	DATES	
NAME			☐ INPATIENT STAYS (Stayed at least overnight)	DATE IN	DATE OUT
STREET ADDRESS				DATE FIRST VISIT	DATE LAST VISIT
CITY	STATE	ZIP	☐ OUTPATIENT VISITS (Sent home same day)	DATE OF VISITS	
PHONE Area Code Phone Number			☐ EMERGENCY ROOM VISITS		

Next **appointment** _____

Reasons for visits _____

What **treatment** did you receive? _____

What **doctors** do you see at this hospital/clinic on a regular basis? _____

If you need more space, use Remarks, Section 9.

F. Does anyone else have medical records or information about your illnesses, injuries or conditions (Workers' Compensation, insurance companies, prisons, attorneys, welfare), or are you scheduled to see anyone else?

☐ YES (If "YES," complete information below.) ☐ NO

NAME			DATES
STREET ADDRESS			**FIRST** VISIT
CITY	**STATE**	**ZIP**	**LAST** SEEN
PHONE Area Code Phone Number		**PATIENT ID #** (if known)	NEXT **APPOINTMENT**

CLAIM NUMBER (If any) _____

REASON FOR VISITS _____

If you need more space, use Remarks, Section 9.

SECTION 5 – MEDICATIONS

Do you currently take any medications for your illnesses, injuries or conditions? ☐ YES
If "YES," please tell us the following: *(Look at your medicine bottles, if necessary.)* ☐ NO

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

If you need more space, use Remarks, Section 9.

SECTION 6 – TEST

Have you had, or will you have any medical test for your illnesses, injuries or conditions?
☐ YES ☐ NO If "YES," please tell us the following: *(Give approximate dates, if necessary.)*

KIND OF TEST	DATE WHEN DONE, OR WHEN IT WILL BE DONE? (Month, day, year)	WHERE WAS IT DONE? (Name of Hospital/Clinic)	WHO SENT YOU FOR THIS TEST?
EKG (HEART TEST)			
TREADMILL (EXERCISE TEST)			
CARDIAC CATHETERIZATION			
BIOPSY – Name of body part _____			
HEARING TEST			
SPEECH/LANGUAGE TEST			
VISION TEST			
IQ TESTING			
EEG (BRAIN WAVE TEST)			
HIV TEST			
BLOOD TEST (NOT HIV)			
BREATHING TEST			
X-RAY – Name of body part _____			
MRI/CT SCAN Name of body part _____			

If you have had other test, list them in Remarks, Section 9.

SECTION 7 – EDUCATION/TRAINING INFORMATION

A. Check the highest grade of school completed.

Grade school: 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 12 ☐ GED ☐

College: 1 ☐ 2 ☐ 3 ☐ 4 or more ☐

Approximate date completed: _____

B. Did you attend special education classes? ☐ YES ☐ NO (If "NO," go to part C)

NAME OF SCHOOL _____

ADDRESS _____
(Number, Street, Apt. No. (If any), P.O. Box, or Rural Route)

_____
City State Zip

DATES ATTENDED _____ TO _____

TYPE OF PROGRAM _____

C. Have you completed any type of special job training, trade or vocational school?
☐ YES ☐ NO If "YES," what type? _____

Approximate date completed: _____

SECTION 8 – VOCATIONAL REHABILITATION, EMPLOYMENT, or OTHER SUPPORT SERVICES INFORMATION

Have you participated, or are you participating in:

- an individual work plan with an employment network under the Ticket to Work Program;
- an individualized plan for employment with a vocational rehabilitation agency or any other organization;
- a Plan to Achieve Self-Support
- an individualized education program through an educational institution (if a student age 18 – 21); or
- any program providing vocational rehabilitation, employment services, or other support services to help you go to work?

☐ YES (Complete the information below) ☐ NO

NAME OF ORGANIZATION _____

NAME OF COUNSELOR _____

ADDRESS _____
(Number, Street, Apt. No. (If any), P.O. Box, or Rural Route)

_____
City State Zip

DAYTIME PHONE NUMBER _____ _____
Area Code Phone Number

DATES SEEN _____ TO _____

TYPES OF SERVICES OR TEST PERFORMED _____
(IQ, vision, physicals, hearing, workshops, etc.)

SECTION 9 – REMARKS

Use this section for any added information you did not show in earlier parts of this form. When you are finished with this section (or if you don't have anything to add), be sure to complete the information at the bottom of this page.

If the person completing this form is someone other than the disabled person or the person identified in Section 1, Item D, please complete the following information

Name of person completing this form if other than the disabled person *(Please Print)*	**Date Form Completed** *(Month, day, year)*
Address (Number and street)	**e-mail address** *(optional)*
City **State**	**Zip Code**

Relationship to Disabled Person	**Daytime Telephone Number** ( ) -

WHOSE Record to be Disclosed	
Name (First, Middle, Last)	
SSN - -	Birthday (mm/dd/yy)

AUTHORIZATION TO DISCLOSE INFORMATION TO
THE DEPARTMENT OF HUMAN RESOURCES (DHR) FAMILY INVESTMENT ADMINISTRATION (FIA)
STATE REVIEW TEAM (SRT)

****PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW****

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange):

OF WHAT 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 and 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) (excludes "psychotherapy notes" as defined in 45 CFR 164.501)
   - Drug abuse, alcoholism, or other substance abuse
   - Sickle cell anemia
   - Records which may indicate the presence of communicable or venereal diseases which may include, but are not limited to, Acquired Immune Deficiency Syndrome (AIDS): and tests for HIV.
   - Gene-related impairments (including genetic test results)
2. Information about how my impairment(s) affects my ability to complete tasks and activities of daily living, and affects my ability to work.
3. Copies of educational tests or evaluations, including Individualized Educational Plans (IEP), trienneial 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.

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 FIA
- Employers
- Others who may know about my condition (family, neighbors, friends, public officials)

THIS BOX IS TO BE COMPLETED BY SRT Additional information to identify the subject (e.g., other names used) the specific sources, or the material to be disclosed:

TO WHOM **The Department of Human Resources and to the State agency authorized to process my case** (usually called "Family Investment Administration")**, including contract copy services, and doctors or other professionals consulted during the process**

PURPOSE Determining my eligibility for benefits, including looking at the combined effect of any impairments that by themselves would not meet the definition of disability.

EXPIRES WHEN This authorization is good for 12 months from the date signed that appears below.

- I authorize the use of a copy (including electronic copy) of this form for disclosure of the information described above.
- I understand that there are some circumstances in which this information may be redisclosed to other parties (see page 2 for details).
- I may write to FIA and my sources to revoke this authorization at any time (see page 2 for details).
- FIA 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 both pages of this form and agree to the disclosures above from the types of sources listed.

PLEASE SIGN USING BLUE OR BLACK INK ONLY **INDIVIDUAL authorizing disclosure** **SIGN ➔**	**IF not signed by subject of disclosure, specify basis for authority to sign** ☐ Parent of minor ☐ Guardian ☐ Other personal representative (explain) **SIGN HERE:**

Date Signed	Street Address		
Phone Number (with area code)	City	State	Zip

WITNESS I know the person signing this form or am satisfied of this person's identity:
SIGN ➔ (OPTIONAL)

Phone Number (or Address)	

This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under P.L. 104-191 ("HIPAA") 45 CFR parts 160 and 164.42 U.S. Code section 290dd-2: 42 CFR part 2; 38 U.S. Code section 7332, 38 CFR 1.475; 20 U.S. Code section 1232g ("FERPA"); 34 CFR parts 99 and 300; Md. Code Ann., Human Services Art. §1-201, Health-General Art.§§4-302-03 and 4-307.

Explanation of Form DHR/FIA 827,

"Authorization to Disclose Information to the State Review Team"

We need your written authorization to help get the information required to process your application. Laws and regulations require that sources of personal information have a signed authorization before releasing it to us. Also, laws require specific authorization for the release of information about certain conditions and from educational sources.

You can provide this authorization by signing a form DHR/FIA 827. Federal law permits sources with information about you to release that information if you sign a single authorization to release all your information from all your possible sources. We will make copies of it for each source. A covered entity (that is, a source of medical information about you) may not condition treatment, payment, enrollment, or eligibility for benefits on whether you sign this authorization form. Some individual sources of information require that the authorization specifically name the source that you authorize to release personal information. In those cases, we may ask you to sign one authorization for each source and we may contact you again if we need you to sign more authorizations.

You have the right to revoke this authorization at any item, except to the extent a source of information has already relied on it to take an action. To revoke, send a written statement to your local department of social service office. If you do, also send a copy directly to any of your sources that you no longer wish to disclose information about you. FIA can tell you if we identified any sources you didn't tell us about. FIA may use information disclosed prior to revocation to determine your eligibility for benefits.

IMPORTANT INFORMATION REGARDING CONFIDENTIALITY

All personal information collected for FIA is protected by Maryland law, including Md. Code Ann., Human Services Art. § 1-201, as well as federal law. Once medical information is disclosed to FIA, it is no longer protected by the health information privacy provisions of 45 CFR part 164 (mandated by the Health Insurance Portability and Accountability Act (HIPAA)). FIA retains personal information in strict adherence to the retention schedules established and maintained as required by Md. Code Ann., State Gov't Art. § 10-611 *et seq.*

The State of Maryland, through DHR/FIA, is authorized to collect the information on form DHR/FIA-827 by section 1902 of the Social Security Act, which sets forth the requirements for states administering the Medical Assistance program. We use the information obtained with this form to determine your eligibility, or continuing eligibility, for benefits. This usually includes review of the information by the State agency processing your case and quality control people in DHR. In some cases, your information may also be reviewed by DHR personnel that process your appeal of a decision, or by investigators to resolve allegations of fraud or abuse, and may be used in any related administrative, civil, or criminal proceedings.

Signing this form is voluntary, but failing to sign it, or revoking it before we receive necessary information, could prevent an accurate or timely decision on your application, and could result in denial or loss of benefits. Although the information we obtain with the form is almost never used for any purpose other than those stated above, the information may be disclosed by DHR without your consent if authorized by Federal and State laws. For example, DHR may disclose information:

1. To enable a third party (e.g., consulting physicians) or other government agency to assist DHR to establish rights to benefits and/or coverage;
2. Pursuant to law authorizing the release of information from DHR records;
3. For statistical research and audit activities necessary to ensure the integrity and improvement of DHR programs.

DHR will not redisclose without proper prior written consent information: (1) relating to alcohol and/or drug abuse as covered in 42 CFR part 2, (2) from educational records for a minor obtained under 34 CFR part 99, Family Educational Rights and Privacy Act (FERPA), or (3) regarding mental health, developmental disability, AIDS or HIV.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, and local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

MARYLAND DEPARTMENT OF HUMAN RESOURCES

311 West Saratoga Street
Baltimore, Maryland 21201-3521

_____ DEPARTMENT OF SOCIAL SERVICES

Name: _____

Address: _____

_____ Client ID: _____

DISABILITY DETERMINATION NOTICE OF ACTION

In deciding whether your illness or injury is disabling, the State Review Team (SRT) reviewed medical and other evidence received from all available sources. After careful review of this evidence, SRT has determined that your condition is not disabling.

Enclosed is an SRT Medical, Vocational, Educational Assessment stating the reason (s) for the decision.

If you do not agree with this decision, you have the right to request a HEARING. You also have the right to re-apply.

_____
CASE MANAGER SIGNATURE

_____
CASE MANAGER PHONE NUMBER

_____
DATE OF NOTICE

MARYLAND DEPARTMENT OF HUMAN RESOURCES
STATE REVIEW TEAM
311 W. SARATOGA STREET
BALTIMORE, MD. 21201-3521

MEDICAL, VOCATIONAL, EDUCATIONAL ASSESSMENT

NAME: **AGE:**

SS# **HEIGHT:**

Client ID # **WEIGHT:**

Dear ,

The State Review Team uses the Social Security Disability criteria to determine disability. The Social Security Administration defines disability as the inability to engage in any substantial gainful activity 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.

In deciding whether your impairment is disabling, the State Review Team (SRT) used the medical and social information you submitted, and when required information from a consultative examination. The following summary gives the reasons for the decision in your case.

STEP TWO: Do you have a severe medically determinable impairment(s)?

A severe impairment is defined as any impairment or combination of impairments which significantly limits your physical or mental ability to do basic work activities. Basic work activities mean the abilities and aptitudes necessary to do most jobs. Pain must be considered as a factor that may limit the performance of one or more of the functions listed below. Examples of this include:

1. Physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying or handling;
2. Capacities for seeing, hearing and speaking;
3. Understanding, carrying out and remembering simple instructions;
4. Use of judgement;
5. Responding appropriately to supervision, co-workers and usual work situation; and
6. Dealing with changes in a routine work setting.

See 3368 form for medical history.

Based on the information received by the SRT the answer is:

( ) YES, continue to STEP THREE

( ) NO, go to DISABILITY DETERMINATION on last page.

STEP THREE: Does your impairment(s) meet or equal a listing of impairment?

The listing of impairments are specific mental or physical health problems described in the Social Security Regulations. The severity of your impairment(s) is assessed against the listings of impairments to determine if you meet or equal the listings. Additional listings of impairments can be found at 20 C.F.R. PT. 404. SUBPT, P. APP. 1

The medical documentation received by SRT shows the following:

Diagnosis:

Medical findings: See medical documentation.

Signs and symptoms: See medical documentation.

Based on the information received by the SRT the answer is:

( ) YES, go to DISABILITY DETERMINATION on last page.

( ) NO, continue to STEP FOUR

Rationale: There was not sufficient medical evidence to support the above ailments as totally disabling impairments under the Social Security's regulations.

Disability Specialist Signature

STEP FOUR: Can you return to past relevant work?

Past relevant work is the kind of work that you have performed (See 3368 form).

The medical documentation received by SRT shows the following:

Physical residual functional capacity assessment:

Mental residual functional capacity assessment:

Residual functional capacity from environmental or other medically determinable impairment(s):

Residual functional capacity from a combination of medically determinable impairment(s):

Exertion level:

Based on the review of this information SRT answered the following:

Do you meet the criteria for first adverse profile (rule I)?

You must have a severe impairment which prevents work at customary level of physical exertion, have 35 years or more of arduous, physical, unskilled work and a marginal education – sixth grade or less.

( ) YES, go to DISABILITY DETERMINATION on last page.

( ) NO, do you meet the criteria for second adverse profile (rule II)?

You must have a severe impairment, advanced age (55 years or older), limited education (11th grade or less) and no relevant work experience.

( ) YES, go to DISABILITY DETERMINATION on last page.

( ) NO, if NO answer the following question.

Can you return to past relevant work?

( ) YES, go to DISABILITY DETERMINATION on last page.

( ) NO, proceed to STEP FIVE

STEP FIVE: Can you perform any other work that exists in the national economy?

The medical documentation received by SRT shows the following:

Assessment of vocational factors:

Age:

Educational level:

Previous work experience:

Do any grid rules apply (exertional impairments only):

Citations of three jobs you should be able to perform from the Dictionary of Occupational Titles:

DISABILITY DETERMINATION: The disability or vocational specialist's determination is you are:

( ) DISABLED ( ) NOT DISABLED

Specialist's Initials	Date	SRT Approval	Date

EMERGENCY SERVICES TO INELIGIBLE ALIENS

Date: _____

TO: Beneficiary Services Administration
Office of Operations & Eligibility
201 West Preston Street
Baltimore, MD 21201

FROM: Local
Department _____
Medical Assistance Unit

Unit
Address: _____

_____

_____

SUBJECT: Determination of Emergency Services – Aliens

Case Name: _____

Case Number: _____

Date of MA Application: _____

I have checked and agree that the technical and financial information for the applicant has been reviewed and meets the MA requirements except for citizenship.
Caseworker
Signature: _____
(Please sign your name)

The above-named applicant has submitted a Medical Assistance application for coverage. of emergency services received from _____ (date) to _____ (date) at _____ .

Federal category for which the applicant is eligible, but for his/her alien status:
☐ FAC ☐ MCHP ☐ Aged ☐ Disabled/Blind

A copy of the following must be attached:

- ☐ MMIS screen 1 or MMIS/CARES screen showing results of search
- ☐ Discharge summary with admission and discharge dates
- ☐ ER admission
- ☐ Documentation showing the emergency nature of the medical services
- ☐ SRT determination (if qualifying as disabled/blind)

***Note: No bills or other extraneous information should be submitted.**