
MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-323 - DISABILITY OR BLINDNESS REPORT

PURPOSE & USE

This form is used to record the applicant's condition and medical background when the applicant is under age 65 and is disabled and/or blind. If the applicant's disability is to be determined by DDS, this form must be completed by the applicant, representative or Specialist based on the applicant's response to the questions on the form. Refer to Section D, Nonfinancial Eligibility, for policy governing DDS decisions.

If the applicant is a child, complete DOM-323A, Disabled Child Questionnaire, in addition to DOM-323.

INSTRUCTIONS

Prepare an original. DOM-323 along with any prior medical information from the case record will be submitted to DDS in accordance with procedures outlined in the Blindness and Disability policy in Section D.

When the Medicaid Specialist or Supervisor completes the form for the applicant or representative, the CONFIDENTIALITY NOTICE portion of the form will be explained to the applicant. The remainder of the form will be completed based on the applicant or representatives responses to the questions. The information should be as detailed as possible for the benefit of the disability reviewer.

DISABILITY OR BLINDNESS REPORT

PLEASE PRINT, TYPE OR WRITE CLEARLY AND ANSWER ALL ITEMS TO THE BEST OF YOUR ABILITY. If you are filing on behalf of someone else, enter his or her name and Social Security Number in the space provided and answer all questions about them. COMPLETE ANSWERS WILL AID IN PROCESSING YOUR APPLICATION PROMPTLY.

CONFIDENTIALITY NOTICE: The information requested on this form is authorized by Title XIX of the Social Security Act. The information will be used to further document your request for Medicaid. Information requested on this form is voluntary, but failure to provide all or any part of the requested information may affect the determination of your eligibility. Information you furnish on the form may be disclosed by the Social Security Administration or the Medicaid Agency to another person or governmental agency only with respect to Social Security and Medicaid programs and only to comply with Federal laws requiring exchange of information between Medicaid and other agencies.

A. NAME OF CLIENT _____ B. SOCIAL SECURITY NUMBER _____ C. CASE NUMBER/MEDICAID NUMBER _____

D. TELEPHONE NUMBER _____ E. WHAT IS YOUR ILLNESS? _____

PART I - INFORMATION ABOUT YOUR CONDITION

1. A. When did your illness or injury first bother you? Give month, day and year.

B. When did your illness or injury finally disable you? Give month, day and year.

C. Explain how your condition affects you and keeps you from working?

2. Have you worked since the date shown in item 1A? Yes No
If no, go on to Part II.

3. If you did work since the date in item 1A did your condition cause you to change --
Your job or job duties? Yes No
Your hours of work? Yes No
Your attendance? Yes No
Anything else about your work? Yes No

(If you answered NO to all of these, go to Part III)

4. If you answered YES to Item 3, explain below what the changes in your work circumstances were, the dates they occurred, and how your condition made these changes necessary:

PART II - INFORMATION ABOUT YOUR MEDICAL RECORDS

5. Have you had any of the following tests in the last year:

Test	Check Appropriate		If "Yes", Show	
	Yes	No	Where Done	When Done
Electrocardiogram	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Chest X-Ray	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Other X-Ray (Name the body part here _____)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Breathing Tests	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Blood Tests	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Other (Specify)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

6. List the name, address and telephone of the doctor who has your latest medical record. If you have no doctor, check here

Name _____ Address _____

Area Code/Telephone No. _____

How often do you see this doctor? _____ Date you last saw this doctor _____

Reason for visits _____

Type of treatment received _____

7. A. Have you seen any other doctor since your illness or injury began? Yes No

Name _____ Address _____

Area Code/Telephone No. _____

How often do you see this doctor? _____ Date you last saw this doctor _____

Reason for visits _____

Type of treatment received _____

B. Identify below any other doctor you have seen since your illness or injury began. List the doctor(s) names, addresses, dates and reasons for visits. If additional space is needed, use Part VI or attach another sheet of paper.

8. Have you been hospitalized or treated at a clinic for your illness or injury? Yes No If "Yes", show the following:

Name of hospital or clinic _____ Address _____

Patient or clinic number _____

Were you an inpatient? (stayed at least overnight) Yes No If "Yes" complete the following:

Date of admission _____ Date of discharge _____

Reason for hospitalization or clinic visits _____

Type of treatment received _____

If you have been in other hospitals or clinics for your illness or injury, list the names, addresses, patient or clinic numbers, dates and reasons for hospitalization or clinic visits in Part VI. Remarks.

Have you been seen by other agencies for your injury or illness? (VA, Worker's Compensation, Vocational Rehabilitation, Welfare, etc) Yes No If "Yes", show the following:

Name of Agency _____ Address _____

Your Claim Number _____

Dates of visits _____

Type of treatment or examination received _____

If more space is needed, list the other agencies, their addresses, your claim numbers, dates, and treatment received in Part VI.

PART III - INFORMATION ABOUT YOUR ACTIVITIES

10. Has any doctor told you to cut back or limit your activities in any way? Yes No If "Yes", give name of doctor and tell what he or she told you about cutting back or limiting your activities: _____

11. Describe your daily activities in the following areas and state what and how often you do it.
Household maintenance (including cooking, cleaning, shopping, and odd jobs around the house as well as any other similar activities):

Recreational activities and hobbies (hunting, fishing, bowling, hiking, musical instruments, etc.):

Social contacts (visits with friends, relatives, neighbors):

Other (drive car, motorcycle, ride bus, etc.):

PART IV - INFORMATION ABOUT YOUR EDUCATION

12. What is the highest grade of school that you completed? _____

13. Have you gone to trade or vocational school or had any other type of special training? Yes No If "Yes", complete the following:
Type of trade or vocational school or training _____
Approximate dates you attended: _____
How this school or training was used in any work you did. _____

PART V - INFORMATION ABOUT THE WORK YOU DID

14. A. If you did work, what was your usual job in the 15 years before you became disabled. (Normally this will be the kind of work you did for the longest period of time.) Include the type of business, for example, farming, restaurant, etc. _____

B. Describe your duties in this job. (Show how much bending, lifting, walking, writing, or other activities were required. How often did you lift things, and how heavy were they? What kind of special tools or skills were required? What kind of written reports did you complete? How many people did you supervise?) _____

15. A. Did your condition make you stop working? Yes No
B. If "Yes", what is the date you stopped working? Give month, day, year
C. If this date is different from the one shown in Item 1B (the date you say you became disabled), explain the reason for the difference: _____

PART VI - REMARKS

Knowing that anyone making a false statement or representation of a material fact for use in determining a right to payment under the Social Security Act commits a crime punishable under Federal law, I certify that the above statements are true.

NAME (Signature of Client or person filing on the Client's behalf)

✓

Date _____

PART VII - FOR MEDICAID USE ONLY - DO NOT WRITE BELOW THIS LINE

Name of Client _____ SSN _____

16. A. Does the client need assistance in prosecuting his/her claim? Yes No If "Yes" show name, address, relationship, and telephone number of an interested party willing to assist the client.

B. Can the client (or his representative) be readily reached by telephone with no communication problems due to language, spec. or hearing difficulties? Yes No If "No" worker should also complete Form DOM-324, Vocational Report.