



DETERMINATION OF MEDICAID DISABILITY Authorization for Release of Medical Information

State Form 1380 (R12 / 5-08) / OMPP 0251A

Prescribed by the Indiana Family and Social Services Administration, Office of Medicaid Policy and Planning

Return form and records to:
County DFR

Address (street address or Rural Route number and city, state, and ZIP code)

CONFIDENTIALITY STATEMENT

The personal information requested on this form will be used in the determination of your entitlement to or continued receipt of Medical Assistance administered by the Indiana Family and Social Services Administration. Disclosure of the information requested is mandatory pursuant to the provisions of IC 12-15 *et seq.* Non-disclosure of the information requested will hamper and possibly prevent the delivery of assistance to you. All personal information collected on this form will be treated as confidential pursuant to 470 IAC 1-2-7 and 470 IAC 1-3-1, 42 CFR 431 Subpart F and 45 CFR 164 Subpart E and 42 CFR Part 2.

NOTICE TO EXAMINING PHYSICIAN

By court order and federal regulation, if the client appeals the decision of the State Medicaid Medical Review Team, this medical information becomes available to the client or his/her legal representative.

DETERMINATION OF DISABILITY: Medical Information

Indiana Law [IC 12-14-15-1(2)] requires that, in order to be eligible for Medical Assistance to the Disabled, a person must have a physical or mental impairment, disease, or loss which appears reasonably certain to result in death or appears reasonably certain to last for a continuous period of at least twelve (12) months without significant improvement and which substantially impairs his/her ability to perform labor or services or to engage in a useful occupation. This is not the same definition of disability that is used by the Social Security Administration, or other agencies.

The law [IC 12-14-15-1 (2) and IC 25-22-5] requires an individual to be examined by a physician holding an unlimited license to practice medicine.

The Medicaid Medical Review Team will make the final disability determination. The records released pursuant to this authorization will be used in making this determination.

SECTION I - IDENTIFICATION (to be completed by County Office, Division of Family Resources)

Name (first, middle, last)

Address (street address or Rural Route number and city, state, and ZIP code)

Date of birth (month, day, year)	Case number
----------------------------------	-------------

SECTION II - AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Date of birth of patient/applicant (month, day, year)	Social Security number of patient/applicant	Case number	Date of consent (month, day, year)
---	---	-------------	------------------------------------

I, _____
First name
Middle initial
Last name

_____ Address (number and street, city, state, and ZIP code)

do hereby authorize _____
Name of person releasing information

_____ Organization releasing information
 _____ Address of organization (number and street, city, state, and ZIP code)

to release the following medical records:

- Entire medical record for the following dates (month, day, year) _____
- Portions of the medical record relating to psychiatric, psychological, or mental health counseling for the dates specified above
- Portions of the medical record relating to alcohol, drug, or other substance abuse treatment for the dates specified above
- Portions of the medical record relating to any communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus (HIV), also known as Acquired Immune Deficiency Syndrome (AIDS); and tests for HIV for the dates specified above

Copies of the records should be furnished to the: _____
Name of local office

_____ Address of local office (number and street, city, state, and ZIP code)

I understand that this information is protected under Federal and State confidentiality and privacy regulations and cannot be disclosed without my written authorization unless otherwise provided for in the regulations.

I understand that, pursuant to IC 16-39-1-4, this consent for release of medical and mental health information is subject to revocation by me at any time, except to the extent that action has been taken in reliance on the consent. By law this consent might normally expire sixty (60) days from the consent date listed above; however, I expressly waive this time limit and consent to release of medical and mental health information for one (1) year from the consent date. This consent may be revoked in writing by contacting the county office listed above.

Signature of applicant or legal representative	Date signed (month, day, year)
--	--------------------------------

If patient is a minor, signature of parent or legal representative	Date signed (month, day, year)
--	--------------------------------

Case number

SECTION III - REPORT OF MEDICAL EXAMINATION

Complete only those sections pertinent to a description of substantial impairment.

A. Current Medical History *(Include the patient's complete medical history for at least 12 months. Attach additional sheets if necessary)*

How long has the patient been treated by you?

Please list all diagnostic tests and/or evaluations performed on the patient and their results.

Please list all treatments performed to-date relative to his / her impairment(s)

What are the patient's current medications including dosage and frequency?

Is the patient compliant with medications and treatment? If No, please explain.

Case number

B. Current Medical Evidence					
Height	Weight		Urinalysis	Sugar	Albumin
Fasting blood sugar test <i>(required if diagnosis is diabetes)</i>					
Blood data <i>(CBC if available)</i>					
Eyes <i>(degree of impairment of vision, if any)</i>					
OS _____					
OD _____					
Ears <i>(degree of impairment of hearing, if any)</i>					
AS _____					
AD _____					
Nose, throat, mouth <i>(describe abnormalities)</i>					
Neck and lymphatic system <i>(describe abnormalities)</i>					
Cardiovascular System					
Blood Pressure	Systolic	Diastolic	Pulse rate	Cardiac enlargement? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, degree
Murmurs? <input type="checkbox"/> Yes <input type="checkbox"/> No	Rhythm		Degree of decompensation		Is there auricular fibrillation? <input type="checkbox"/> Yes <input type="checkbox"/> No
Ever on digitalis? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, when?			Angina pectoris? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Evidence of past myocardial infarction? <input type="checkbox"/> Yes <input type="checkbox"/> No			If Yes, date occurred		
Ever on antihypertensive drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, when?		Response	
Dyspnea? <input type="checkbox"/> Yes <input type="checkbox"/> No	Cyanosis? <input type="checkbox"/> Yes <input type="checkbox"/> No	Edema? <input type="checkbox"/> Yes <input type="checkbox"/> No		Type of heart disease <i>(please use A.H.A. classification)</i>	
<i>If cardiac disease, attach current EKG, treadmill, catheterization or other interpretations.</i>					
Condition of palpable arteries			Varicosities		
Chest: Normal? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If No, complete the rest of this section.</i>					
Describe abnormalities					
Asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No	Frequency of attacks <input type="checkbox"/> Daily <input type="checkbox"/> Monthly		Severity	Medication	
Tuberculosis? <input type="checkbox"/> Yes <input type="checkbox"/> No	Active	Arrested	Pulmonary obstructive disease? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If chest disease, describe and attach current x-ray report					
<i>If emphysematous, send pulmonary function test results.</i>					

Case number

Nervous System: *If the disability determination is to be based upon any of the following, enter a brief explanation of the degree of deterioration and attach appropriate evidence.*

Organic (*describe senility, tremors, atrophy, speech problems, gait, paralysis, epilepsy*)

Non-Organic (*describe evidence of psychosis or other mental disorder, including functional restrictions of daily activities and interests, the deterioration in personal habits and ability to relate to other persons*)

Please indicate whether you recommend a psychological/psychiatric mental status evaluation <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, briefly state the reason(s) for your recommendation, including a description of mental status, defects or problems (<i>if applicable</i>)
--	---

Mental Deficiency: *This section must be completed if there is a diagnosis of mental retardation.*

Full scale I.Q.	Or estimated mental age	Is the patient mentally capable of handling his/her own affairs? <input type="checkbox"/> Yes <input type="checkbox"/> No
-----------------	-------------------------	--

Musculo - Skeletal System: Bones, joints and extremities normal? Yes No

If No, describe disease, defect or injury and state limitation of motion. Attach x-ray report, if available

Arthritis? <input type="checkbox"/> Yes <input type="checkbox"/> No	Type
--	------

Describe deformities

Case number

Neoplasms: Yes No

Site	<input type="checkbox"/> Benign <input type="checkbox"/> Malignant	Metastasis? <input type="checkbox"/> Yes <input type="checkbox"/> No
------	--	---

If Yes to Metastasis, location (*explain*) - Please give clinical stage, if known.

Abdomen:

Describe abnormalities

Hernia? <input type="checkbox"/> Yes <input type="checkbox"/> No	Describe
---	----------

Genito - Urinary: (*describe abnormalities*)

Gynecological: (*describe abnormalities*)

Ano - Rectal: (*describe abnormalities*)

SECTION IV - DIAGNOSIS / PROGNOSIS

1. List below the patient's present diagnoses and your prognosis after treatment, of each disorder. Indicate if the disorder can be controlled, resolved, or improved by treatment. **PLEASE INDICATE PRIME DIAGNOSIS(ES) FIRST.**

Diagnosis	Date Began	Date Condition Began Affecting Ability To Perform Labor/Services	Prognosis After Treatment
A. PRIME:			
B. PRIME:			
C. SECONDARY:			
D. SECONDARY:			
E. SECONDARY:			

Case number

2. Does the patient's impairment(s), taken together or individually, currently affect his/her ability to perform labor or services or engage in a useful occupation? If so, is the patient's inability to work temporary or is it likely to continue? What is the basis for this conclusion?

3. Is additional consultation or diagnostic evaluation / testing necessary to clarify the degree of impairment? If so, please specify the type of consult / exam / test required. Additional testing / exams may only be performed if prior-authorized by the Medicaid Medical Review Team physician. In order to request prior authorization, please call (317) 234-2107.

4. What are the standard treatment options to correct, improve or control the patient's condition(s)?

Do medical reasons prevent standard treatment options? *(If Yes, please explain)*

Yes No

Is it expected that the patient's functional limitations will improve with regular medical care and / or the treatment options listed above?

Yes No

a. If the functional limitations **will improve**, please explain:

How will they improve?

Are they expected to improve enough to enable the person to perform labor or services or engage in a useful occupation?

Yes No

If Yes, how long is the duration of the limitation expected to last before the patient is able to perform labor or services or engage in a useful occupation?

0-under 1 year 1-2 years 3-4 years greater than 4 years

b. If the functional limitations are **not expected to improve**, please explain:

Why will they not improve?

Are the limitations substantial enough to impair the individual's ability to perform labor or services or engage in a useful occupation?

Yes No

Are the limitations substantial enough to impair the individual's ability to perform labor or services or engage in a useful occupation?

Yes No

Case number

5. Capacity and Limitations

Can the patient currently carry out normal activities? Yes No

If No, specify, using the list below, how his/her condition affects activities or mobility by checking off the degree of severity as either not significant, moderate or significant. Please indicate in column 4 below whether the limitations are expected to continue even after regular medical care and / or treatment options as listed in Question 4 have been explored.

LIMITATIONS					
ACTIVITY	NOT SIGNIFICANT	MODERATE	SIGNIFICANT	WILL LIMITATION CONTINUE AFTER TREATMENT?	
				YES	NO
Sitting					
Standing					
Walking					
Lifting					
Grasping / Manipulation					
Pushing / Pulling					
Bending					
Squatting					
Crawling					
Climbing					
Reaching Above Shoulders					
Being Around Machinery					
Driving					
Repetitive Leg Movements					
Exposure To Temperature / Humidity Changes					
Exposure To Dust, Fumes or Gases					
Normal Housework					
Caring For Personal Needs					

6. Additional Comments

PHYSICIAN'S CERTIFICATION

* A stamp or the signature of a person other than the examining physician is not acceptable.

I certify that I examined this person on _____
Date of examination (month, day, year)

Signature of examining physician *

Printed or typed name of examining physician

Date signed (month, day, year)

Indicate physician specialty