

Disability Report

Medical Disability Decision
DSHS 14-144A

The Disability Report form, DSHS 14-144A, gathers information about a client's disability, medical evidence, and work history for use by the Division of Disability Determination (DDDS) in determining medical disability.

The Social Service Specialist (SSS) or Financial Service Specialist (FSS) initiates the DSHS 14-144A. The SSS or FSS should ensure that the Community Service Office (CSO), and telephone number are noted on the form. Check the appropriate box to indicate that the disability decision requested is for Non-Grant Medical Assistance (NGMA) or Healthcare for Workers with Disabilities (HWD). Add the completed form to the disability decision packet.

1. The SSS or FSS completes the heading to indicate the name, Social Security Number (SSN), and disabling condition of the client.
2. The SSS or FSS may assist the client to complete Part 1 - Information About Your Condition. Dates need not be exact, but should reflect month and year.
3. The SSS or FSS may assist the client to complete Part 2 - Information About Your Medical Records. It is important to identify physicians and treatment sources as completely as possible.
4. The SSS or FSS may assist the client to complete Part 3 - Information About Your Activities. The SSS or FSS should review information to ensure client's limitations are clearly identified.
5. The SSS or FSS may assist the client to complete Part 4- Information About Your Education. It should be noted if school classes were Special Education classes.
6. The SSS or FSS may assist the client to complete Part 5 - Information About the Work You Did. Individual employers should not be listed, only the type of business.
7. The SSS or FSS may assist the client to complete Item 1 in Part 6 - Remarks. Items 2 through 6 are to be completed by the SSS or FSS.

Disability Report

Medical Disability Decision

REQUEST IS FOR:	
<input type="checkbox"/>	Non-Grant Medical Assistance (NGMA)
<input type="checkbox"/>	Healthcare for Workers with Disabilities (HWD)

This form is completed by a DSHS social services or financial worker during an interview with the claimant or claimant's representative. **Please print, type, or write clearly and answer all items to the best of your ability. Answer all questions. Complete answers help process the claim. If you need more space to answer any of the questions in the form, go to part 6 or attach additional sheets.**

1. CLAIMANT'S NAME / ALIAS	2. SOCIAL SECURITY NUMBER	3. TELEPHONE NUMBER (AND AREA CODE)
4. THIRD PARTY CONTACT NAME		TELEPHONE NUMBER (AND AREA CODE)
ADDRESS		

5. WHAT IS YOUR DISABLING CONDITION? BRIEFLY EXPLAIN THE INJURY OR ILLNESS THAT PREVENTS YOU FROM WORKING.

PART 1. INFORMATION ABOUT YOUR CONDITION

1. What date did your condition first bother you? _____
MONTH DAY YEAR

2A. Did you work after the date shown in item 1 above? If you answered **NO**, go to 3A and 3B. below. YES NO

2B. **If you answered yes to 2A**, did your condition cause you to change:

Your job or job duties?.....	<input type="checkbox"/>	<input type="checkbox"/>
Your hours of work?	<input type="checkbox"/>	<input type="checkbox"/>
Your attendance?	<input type="checkbox"/>	<input type="checkbox"/>
Anything else about your work?	<input type="checkbox"/>	<input type="checkbox"/>

2C. **If you answered yes to any item in 2B**, explain what the changes in your work circumstances were, the dates they occurred, and how your condition made these changes necessary:

3A. When did your condition finally make you stop working? _____
MONTH DAY YEAR

3B. Explain how your condition now keeps you from working:

PART 2. INFORMATION ABOUT YOUR MEDICAL RECORDS

1. Enter the following information about the doctor who has the latest medical records about your disabling condition:	<input type="checkbox"/> Check here if you have never seen a doctor for your disabling condition.
DOCTOR'S NAME / CLINIC	TELEPHONE NUMBER (AND AREA CODE)
ADDRESS	DATE YOU <u>FIRST</u> SAW THIS DOCTOR
ILLNESS OR INJURY FOR WHICH YOU HAD AN EXAMINATION OR TREATMENT	DATE YOU <u>LAST</u> SAW THIS DOCTOR
TYPE OF TREATMENT OR MEDICINES RECEIVED (I.E., SURGERY, CHEMOTHERAPY, RADIATION, AND THE MEDICINES YOU TAKE FOR YOUR ILLNESS OR INJURY, IF KNOWN. IF NO TREATMENT OR MEDICINES, WRITE <u>NONE</u> .)	
2. Have you seen any other doctors since your disabling condition began? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, answer the following:	
DOCTOR'S NAME / CLINIC	TELEPHONE NUMBER (AND AREA CODE)
ADDRESS	DATE YOU <u>FIRST</u> SAW THIS DOCTOR

ILLNESS OR INJURY FOR WHICH YOU HAD AN EXAMINATION OR TREATMENT	DATE YOU <u>LAST</u> SAW THIS DOCTOR			
TYPE OF TREATMENT OR MEDICINES RECEIVED (I.E., SURGERY, CHEMOTHERAPY, RADIATION, AND THE MEDICINES YOU TAKE FOR YOUR ILLNESS OR INJURY, IF KNOWN. IF NO TREATMENT OR MEDICINES, WRITE <u>NONE</u> .				
<i>If you have seen additional doctors since this illness or injury, attach additional pages with the above information.</i>				
3. Have you been treated at a hospital for your disabling condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, answer the following:				
NAME OF HOSPITAL	TELEPHONE NUMBER (AND AREA CODE)			
ADDRESS				
WHAT WERE THE DATES OF YOUR VISITS?				
ILLNESS OR INJURY FOR WHICH YOU HAD AN EXAMINATION OR TREATMENT				
TYPE OF TREATMENT OR MEDICINES RECEIVED (I.E., SURGERY, CHEMOTHERAPY, RADIATION, AND THE MEDICINES YOU TAKE FOR YOUR ILLNESS OR INJURY, IF KNOWN. IF NO TREATMENT OR MEDICINES, WRITE <u>NONE</u> .				
4. If you have been in other hospitals for your illness or injury, answer the following:				
NAME OF HOSPITAL	TELEPHONE NUMBER (AND AREA CODE)			
ADDRESS				
WHAT WERE THE DATES OF YOUR VISITS?				
ILLNESS OR INJURY FOR WHICH YOU HAD AN EXAMINATION OR TREATMENT				
TYPE OF TREATMENT OR MEDICINES RECEIVED (I.E., SURGERY, CHEMOTHERAPY, RADIATION, AND THE MEDICINES YOU TAKE FOR YOUR ILLNESS OR INJURY, IF KNOWN. IF NO TREATMENT OR MEDICINES, WRITE <u>NONE</u> .				
<i>If you have been in other hospitals or clinics for your illness or injury, list the names, dates and reasons in Part 6 or attach additional pages.</i>				
5. Have you had any of the following tests in the last year? Check the appropriate box below and, if you answer "yes," give where and when the test was done.				
TEST	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 (specify type):	<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"/>		

PART 2. MEDICATION LIST

NAME OF MEDICATION	PRESCRIBED BY (NAME OF DOCTOR)	REASON FOR MEDICATION

If you use more medications, attach additional pages with the above information.

PART 4. INFORMATION ABOUT YOUR EDUCATION

1. **What is the highest grade of school that you completed?** _____ What year? _____
2. Have you gone to trade or vocational school or had any type of special training? Yes No
If yes, answer the following:

TYPE OF TRADE OR VOCATIONAL SCHOOL OR TRAINING	APPROXIMATE DATES YOU ATTENDED
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HOW THIS SCHOOLING OR TRAINING WAS USED IN ANY WORK YOU DID

PART 5. INFORMATION ABOUT THE WORK YOU DID

List all jobs you have had in the last 15 years before you stopped working, beginning with your usual job. This means the kind of work you did the longest. If you have 6th grade education or less, AND did only heavy unskilled labor for 35 years or more, list all of the jobs you have had since you began to work. If you need more space, either attach additional pages or use Part 6.

JOB TITLE	TYPE OF BUSINESS	FROM	TO	DAYS PER WEEK	RATE OF PAY (PER HOUR, DAY, WEEK, MONTH, OR YEAR)

- 2A. In your usual job listed above, did you:
- | | | |
|--|--------------------------|--------------------------|
| | YES | NO |
| Use machines, tools, or equipment of any kind?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Use technical knowledge or skills? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do any writing, complete reports, or perform similar duties? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have supervisory responsibilities: | <input type="checkbox"/> | <input type="checkbox"/> |
- 2B. Explain all yes answers by giving a full description of: the types of machines, tools, or equipment you used and the exact operation you performed; the technical knowledge or skills involved; the type of writing you did, and the nature of any reports; and the number of people you supervised and the extent of your supervision.

2C. Describe the kind and amount of physical activity your usual job involved during a typical day by checking the best answer below.

How many hours a day did you: Walk? 0 1 2 3 4 5 6 7 8
Stand? 0 1 2 3 4 5 6 7 8
Sit? 0 1 2 3 4 5 6 7 8

How often a day did you: Bend? Never Occasionally Frequently Constantly
Reach? Never Occasionally Frequently Constantly

Lifting and carrying: describe what was lifted and how far it was carried.

What was the heaviest weight you lifted? 10 lbs. 20 lbs. 50 lbs. 100 lbs. Over 100 lbs.

What was the weight you frequently lifted or carried? Up to 10 lbs. Up to 25 lbs. Up to 50 lbs.
 Up to 100 lbs.

PART 6. REMARKS

1. Use this section for additional space to answer any previous questions. Also use this space to give any additional information that you think will be helpful in making a decision in your disability claim (such as information about other illnesses or injuries not listed previously).

TO BE COMPLETED BY INTERVIEWER

2. Does the claimant speak English? Yes No If no, what language doe he/she speak:

3. Does the claimant need assistance processing his or her claim? Yes No

If yes, complete the third party contact on Page 1.

4. Check which difficulties below, if any, were observed while interviewing the claimant.

Reading Writing Answering questions Hearing
 Sitting Understanding Using hands Breathing
 Seeing Walking Other (specify):
 NONE OBSERVED

If any of the above items were checked, describe the exact difficulty involved:

5. Any pending / current ABD evaluations? Yes No

Physical; date: _____

Mental Health; date: _____

6. Describe the claimant fully (e.g., general build, height, weight, behavior, any difficulties that add to or supplement those noted above):

INTERVIEWER'S SIGNATURE

DATE

INTERVIEWER'S NAME (TYPE OR PRINT)

INTERVIEWER'S TELEPHONE NUMBER (AND AREA CODE)

COMMUNITY SERVICES OFFICE