Medicaid Disability Application
Objectives

• Understand how to accurately complete a Medicaid Disability Application
• Effectively assist clients with filling out an application
• Reduce delays in application processing
• Reduce amount of incomplete/inaccurate applications
Who Determines Disability

• Blindness or disability is determined by:
  – Social Security Administration (SSA)
    • Receiving Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI)
  – The State Disability Contractor
    • Action Review Group (ARG)
• Same criteria is used by both
  • Called the Sequential Evaluation
  • ARG may use a limited evaluation for adults only
ARG Determination

• Full Disability Criteria:
  – Inability to engage in any substantial gainful activity
  – Must be physically or mental impaired
  – Expected result in death or which has lasted or expected to last for a continuous period of not less than 12 months

• Limited Disability Criteria:

• Substantial Gainful Activity (SGA)
  – Does not need to perform on a full time basis, could be performed on a part time basis
  – Individuals who have worked in recent years
  – Usually worked 5 out of the last 10 years
Disability Application

• The Medical Assistance Application must be received at an eligibility site

• Determine if the applicant needs to complete the Medical Disability Application
  – If the applicant is age 65 or older, the disability application is not required
  – If the applicant is receiving SSI or SSDI the disability application is not required
Disability Application

• The Medical Disability Application and forms can be located at www.Colorado.gov/hcpf

  – Click on Applications
  – Applications and Forms are both in English and Spanish
    - Disability Application
    - Release Form
MEDICAID DISABILITY APPLICATION INSTRUCTIONS

Please read all information before you complete of this form.

IF YOU NEED HELP

If you need help with this form, do as much of it as you can, and then your county technician will help you finish it.

HOW TO COMPLETE THIS FORM

The information that you give on this form will be used to decide if you meet the disability criteria for Medicaid benefits in Colorado. Please remember that being found disabled does not guarantee you will receive Medicaid. You must meet all of the eligibility criteria, which includes disability, These include 1) disability 2) financial and 3) level of care to receive Medicaid.

- Please fill out as much of this form as possible.
- 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."
- Each address should include a Zip Code. Each phone number should include an Area Code. You must provide complete information for each doctor you identify on this form. Failure to provide complete information may result in those medical records not being used to make a decision on your case.
- Do not ask a doctor or hospital to complete this form. But, you may get help from a friend, counselor, case manager, County Medicaid technician, or family member.
- Be sure to explain an answer if the question asks for detail or if you want to give additional information.
- If you need more space or want to tell us more about an answer, please use the “REMARKS” in Section 8 on page 10. Show the number of the question being answered.
- You may send copies of any medical records you have with this application.
Question C:
An address where
the client can be
contacted **MUST**
be provided

- Address needs to
be a location
where mail delivery
can be guaranteed

- The address can
be that of the
person listed under
Question “E”

- “Homeless” is
not acceptable. A
genral delivery
address can be
given

Date of application is essential to protect
the client’s rights and
also to protect the
eligibility site when
processing is taking
too long.
Please list the date
that the Disability
application was
received by the
eligibility site

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**MEDICAID DISABILITY**

**APPLICATION**

**County**

**Date of Application**

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Section 1 – Information About The Disabled Person(s)

A. **Name** (First, Middle Initial, Last)  
B. **Social Security Number**

C. **Address** (Street, City, State, and Zip Code)

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D. **Daytime Telephone Number** (If you have no phone where you can be reached, give us a daytime number where we can leave a message for you.)

(____)_________________

This is □ Your number □ Message □ None

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E. Give the name of a friend or relative that we can contact (other than your doctor) who knows about your conditions and can help you with your application.

Name ______________________ Relationship ______________________

Mailing Address ______________________

(Number, Street, Apt. No. [if any], P.O. Box, or Rural Route)

City __________________ State __________ Zip _______ (_____)

Phone ______________________

---

F. What is your height without shoes?  

Feet _______ Inches _________

G. What is your weight without shoes?  

Pounds ______

H. What is your:  

Date of Birth ___________________ Age ___________ Sex _______
Questions I, J, and K:
• Important to determine the applicant’s ability to work or learn new job skills

Section 2 questions:
The alleged impairment(s) must be specific

• General complaints such as: “my back hurts” or “I have stomach pains.” is not appropriate

• Must be medically diagnosed impairments that prevent working
G. Did you work at any time after the date your conditions first bothered you?  
☐ Yes  ☐ No

H. If “Yes,” did your 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? ____________________

J. Why did you stop working? ______________________________________

K. Have you ever applied for Social Security Disability Income (SSDI) or Supplemental Security Income (SSI)?  ☐ Yes  ☐ No

If “Yes,” on what date did you file the most recent application? ________________

At which Social Security Office did you apply? ________________________________

Was your Social Security claim:  ☐ Allowed  ☐ Denied  ☐ Still pending

---

### Section 3 – Information About Your Work

A. List the kinds of jobs that you had during last 15 years that you worked.

<table>
<thead>
<tr>
<th>Job Title (see example)</th>
<th>Type of Business</th>
<th>Dates Worked (month/year)</th>
<th>Hours Per Day</th>
<th>Days Per Week</th>
<th>Rate of Pay (Per hour, day, week, month, or year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cook</td>
<td>Restaurant</td>
<td>9/99–10/02</td>
<td>8</td>
<td>5</td>
<td>$7.00 hour</td>
</tr>
<tr>
<td></td>
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</tr>
</tbody>
</table>
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” in Section 8.)

______________________________________________________________

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 do each of the following:
- Walk _______  
- Kneel (bend legs to rest on knees) _______
- Stand _______  
- Crouch (bend legs and back down and forward) _______
- Sit _______  
- Handle, grab, or grasp big objects _______
- Climb _______  
- Crouch (bend legs and back down and forward) _______
- Stoop (bend down and forward at waist) _______
- Reach overhead _______
- Handle small objects, write, or type _______

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

G. Check the heaviest weight lifted:
□ Less than 10 pounds □ 10 pounds □ 20 pounds
□ 50 pounds □ 100 pounds or more □ Other_____

H. Check the weight frequently lifted:
(Frequently means from 1/3 to 2/3 of the workday.)
□ Less than 10 pounds □ 10 pounds □ 20 pounds
□ 50 pounds □ 100 pounds or more □ Other_____

I. Did you supervise other people in this job? □ Yes □ No
If “No,” go to Section 4; If “Yes,” complete the following.
- How many people did you supervise? _______
- What part of your time was spent supervising people? _______ hours
- 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 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, including your maiden or married names.

________________________________________  __________________________________

Tell us who may have medical records or other Information about your conditions.

D. List each doctor/clinic/therapist/medical professional you have used. Use an extra sheet, if needed. Include your next appointment.

<table>
<thead>
<tr>
<th>Name</th>
<th>Street Address</th>
<th>Date First Seen</th>
<th>Date Last Seen</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
<th>Phone ( )</th>
<th>Next Appointment</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

Reason(s) for Visits

What treatment was received?

Question D:

The name, address, and phone number of all doctors the applicant has seen in the last two years is essential.

• Not listing a provider may result in a denial for insufficient evidence
<table>
<thead>
<tr>
<th>Name</th>
<th>Street Address</th>
<th>Date First Seen</th>
</tr>
</thead>
<tbody>
<tr>
<td>City</td>
<td>State</td>
<td>Zip</td>
</tr>
<tr>
<td>Phone</td>
<td></td>
<td>Next Appointment</td>
</tr>
<tr>
<td>Reason(s) for Visits</td>
<td></td>
<td></td>
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<tr>
<td>What treatment was received?</td>
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</tbody>
</table>

If you need more space, use “Remarks” in Section 8.
E. List each **hospital** you have used. Include your **next appointment**.

<table>
<thead>
<tr>
<th>Name</th>
<th>Street Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
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<table>
<thead>
<tr>
<th>Phone</th>
<th>Type of Visits</th>
<th>Date In</th>
<th>Date Out</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ Inpatient Stays (stayed at least overnight)</td>
<td>Date of First Visit</td>
<td>Date of Last Visit</td>
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<tr>
<td></td>
<td>□ Outpatient Visits (sent home same day)</td>
<td>Date</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Emergency Room Visits</td>
<td>Date</td>
<td></td>
</tr>
</tbody>
</table>

If you need more space, use “Remarks” in Section 8.

**Question E:**

The name, address, and phone number of all hospitals the applicant has used in the last two years is essential.

- Not listing a hospital may result in a denial for insufficient evidence.
### Section 5 – Tests

Have you had any medical tests for your conditions?  
☐ Yes  ☐ No  
(If “Yes,” complete the information below.)

<table>
<thead>
<tr>
<th>Kind of Test</th>
<th>When was test done? (month/day/year)</th>
<th>Where was test done? (Name of facility)</th>
<th>Who sent you for this test?</th>
</tr>
</thead>
<tbody>
<tr>
<td>EKG (heart test)</td>
<td></td>
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<tr>
<td>Treadmill (exercise test)</td>
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<tr>
<td>Biopsy – Name of body part</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Hearing Test</td>
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<td></td>
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<td>Vision Test</td>
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<td>IQ Test</td>
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<tr>
<td>EEG (brain wave test)</td>
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<tr>
<td>HIV Test</td>
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<tr>
<td>Blood Test (not HIV)</td>
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<tr>
<td>Breathing Test</td>
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<tr>
<td>X-Ray – Name of body part</td>
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<tr>
<td>MRI/CT Scan – Name of body part</td>
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<tr>
<td>Other – Name of test and on what body part</td>
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</tr>
</tbody>
</table>

If you have had other tests, list them in “Remarks” in Section 8.

---

**Section 5**

This information may evaluate impairments that the applicant may not have stated.

• Can lead to allowances for impairments that the applicant did not know were disabling.
### Section 6 - Medications

Do you currently take any medications for your conditions? □ Yes □ No

*If “Yes,” please tell us the following information:*

(Look at your medicine bottles, if necessary.)

<table>
<thead>
<tr>
<th>Name of Medicine</th>
<th>If prescribed, give name of doctor</th>
<th>Reason for Medicine</th>
<th>Side effects from the Medicine</th>
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</table>

### 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 11 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. If “Yes,” complete the following information:*

Name of School ____________________________________________

Address __________________________________________________

(Number, Street, Apt. No. [if any], P.O. Box, or Rural Route)

Date Attended ____________________________________________

City ___________________________ to ___________________________ State Zip ___________________________

Type of Program ____________________________________________

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**Section 7 Questions**

- Information may seem strange to request for a medical disability determination, but it **MUST** be included.
- It is used to determine what types of other work, if any, the applicant might be able to do.
Section 8 – Remarks

Use this section for any additional information you did not share in an earlier parts of this form. When you have completed this section (or if you don't have anything to add), go to the next page and complete the signature block.
By signing this application, I affirm that everything is true to the best of my knowledge. I understand that I am giving the Department of Health Care Policy and Financing and its designees the authority to make the necessary contacts to verify any statements made on this application and to request all records/information necessary to determine medical disability eligibility. I understand that this application does not guarantee any benefits will be paid to me or on my behalf.

<table>
<thead>
<tr>
<th>Signature of claimant or person filing on claimant’s behalf (parent, guardian)</th>
<th>Date (Month, day, year)</th>
</tr>
</thead>
</table>

Witnesses are required ONLY if this statement has been signed by an (X) mark above. If signed by an (X) mark, two witnesses to the signing who know the person making the statement must sign below, giving their full addresses.

<table>
<thead>
<tr>
<th>1. Signature of Witness</th>
<th>2. Signature of Witness</th>
</tr>
</thead>
</table>

| Address (number and street, city, state, and zip code) | Address (number and street, city, state, and zip code) |
Eligibility Staff should make comments here

County Technician's Comments:

<table>
<thead>
<tr>
<th>Technician’s Printed Name</th>
<th>Technician’s Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>County Department</td>
<td>Date</td>
</tr>
<tr>
<td>Telephone Number</td>
<td>Email address</td>
</tr>
<tr>
<td>Supervisor’s Name</td>
<td>Supervisor’s Telephone Number</td>
</tr>
</tbody>
</table>
If you want or need someone to help you with your claim, please complete this form

DESIGNATION OF PERSONAL REPRESENTATIVE
For the Use and Disclosure of Protected Health Information

The Health Insurance Portability and Accountability Act of 1996 states that you have the right to have one or more persons act as your representative to make decisions about the uses and sharing of your protected health information. You can limit the amount of protected health information that the authorized personal representative(s) can decide about, and you can cancel this at any time. See the Department’s Privacy Policy and Procedures on Personal Representatives, pursuant to 45 C.F.R. 164.502(g).

Date: ________________

DESIGNATION OF PERSONAL REPRESENTATIVE

I, ___________________________ (print your name) hereby name the following person to act as my authorized personal representative with respect to decisions involving the use and/or sharing of protected health information that pertains to me.

Name of Personal Representative ____________________ Relationship to Applicant _____________________

Personal Representative Social Security # ____________________ Personal Representative Phone _____________________

LIMITS TO THE AMOUNT OF INFORMATION PROVIDED – Please check one

   _____ The person named above is to be given all of the privileges that would be given to me with respect to my protected health information.

   _____ The person named above is acting as my designated personal representative ONLY for the following function(s):

   _____________________________________________________________

   _____________________________________________________________

State ID number: ___________________ Applicant signature: ____________________

Date of birth: _______________________ Social Security #: ______________________

REVOCATION SECTION

I understand that I may cancel this designation at any time by signing the revocation section below and returning it to the Department’s Privacy Officer at the above address. I understand that any revocation can only apply to future disclosures or actions regarding my protected health information and cannot cancel actions taken or disclosures made while the designation was in effect.

I no longer want this person to act as my personal representative.

Signature: __________________________ Date: ______________________

Do not sign unless revoking personal representative
HOW TO COMPLETE MEDICAL RELEASE FORMS

- **Only your signature is needed.** Sign your full name in the space marked “INDIVIDUAL authorizing disclosure.”
- Sign each release form.
- Leave all other areas blank. **Do not date** the release forms.
- You need to sign **one (1) release for every doctor or hospital** you have listed on this form. You also need to sign **three (3) additional** release forms for any new or discovered medical sources.
- If you do not have enough release forms, please contact your county technician to get more.

REQUEST ENOUGH RELEASE FORMS

Count the number of doctors, hospitals, and medical sources you listed in the application and write that number on this line.

A. _______

The number of extra release forms you need is 3

B. ____ + 3

TOTAL: A + B = C. Add the number you listed in A and the number listed in B. That tells you the total number of release forms you need.

C. _______

*If the number of release forms listed in “C” is more than you have in the application packet, call your county worker and ask them to send you more.*
Applicant must sign this and any additional forms.

If the applicant is unable to sign:

- A **Durable Power of Attorney** stating that someone else has the power to request medical records must be attached to the application.

- A standard Power of Attorney is not sufficient.

Sign Only! Do Not date or fill out any other information.

Applicant fills out everything except gray portion.
EXPLANATION OF FORM MEDICAL RELEASE 2 “AUTHORIZATION TO DISCLOSE INFORMATION TO ARBOR E&T, LLC ACTION REVIEW GROUP (ARG)”

We need your written authorization to help get the information required to process your application for benefits, and to determine your capability of managing benefits. 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 ARG Release 2. 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 few States, and 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 time, except to the extent a source of information has already relied on it to take an action. To revoke, send a written statement to ARG. If you do, also send a copy directly to any of your sources that you no longer wish to disclose information about you; ARG can tell you if we identified any sources you didn't tell us about. Information disclosed prior to revocation may be used by ARG to decide your claim.

It is ARG's policy to provide service to people with limited English proficiency in their native language or preferred mode of communication consistent with Executive Order 13166 (August 11, 2000) and the Individuals with Disabilities Education Act. ARG makes every reasonable effort to ensure that the information in the ARG Release 2 is provided to you in your native or preferred language.

IMPORTANT INFORMATION, INCLUDING NOTICE REQUIRED BY THE PRIVACY ACT

All personal information collected by ARG is protected by the Privacy Act of 1974. Under a Business Associate Agreement with the State of Colorado (HCDF), your private health information will not be used for any purpose other than to make a medical decision determination. Your personal health information remains protected under the health information privacy provisions of 45 CFR 164 (mandated by the Health Insurance Portability and Accountability Act (HIPAA)). After a medical determination is made and the necessary waiting period for appeal purposes has passed, all medical information is sent to the county where you applied. Once the medical information is returned to the county, it will be destroyed in order to protect your personal health information.

ARG is authorized to collect the information on form ARG Release 2 by section 205(a), 233 (d)(5)(A), 1614(a)(3)(H)(I), 1633(d)(1) and 1631 (3)(1)(A) of the Social Security Act. We use the information obtained with this form to determine your eligibility for benefits and your ability to manage any benefits received. This use usually includes review of the information by the State agency processing your case and quality control people in ARG. In some cases, your information may also be reviewed by Administrative Law Judges and by Health Care Policy and Financing (HCDF) 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 determination on your claim, and could result in denial or loss of benefits. The information we obtain with this form will only be used for the purposes of determining eligibility for Medicaid. The only two instances where your information will be released will be:

1. To enable a third party (e.g. consulting physician) or other government agency to assist ARG to determine eligibility for Medicaid.

2. To provide necessary medical information for the purpose of consulting examinations. Other than the above limited circumstances, ARG will not disclose any medical information without proper prior written consent information (1) relating to alcohol and/or drug abuse as covered in 42 CFR part 2, or (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, or local government agencies. Agencies use matching programs only 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.

Explanations about possible reasons why information you provide may be used or given out are available upon request from ARG or HCDF.

PAPERWORK REDUCTION ACT

This information collection meets the requirements of 44 U.S.C. 3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 10 minutes to read the instructions, gather the facts, and answer the questions. SEND THE COMPLETED FORM TO: Arbor E&T, Action Review Group, PO Box 346, Olney, PA 19447. You may FAX it to ARG at 1-877-972-2077. You may call ARG at 1-877-265-1854. Email: actionreviewgroupmri@arborist.com.
Disability Application Submission

Once the application has been completed, either the Eligibility Site or worker must **SEND THE COMPLETE APPLICATION AND RELEASE FORMS TO:**

Arbor E&T, Action Review Group,
P.O. Box 340
Olyphant, PA 18447

OR

Fax to 877-672-2077

Additional contact information:
Phone: 877-265-1864
Email: actionreviewgroup@arboret.com
Reminders for the Applicant

• Include a signed release form for every medical provider and three (3) additional forms for any new or discovered medical sources after the date of application

• All fields are required. Failure to do so will either result in a delay of processing or the application being sent back as an incomplete form

• Applicant must contact the Eligibility Site if there are changes to the applicant’s:
  – Address
  – Phone number
  – Medical history (see new doctors, hospitalized)
Questions?

QUESTIONS ANSWERED HERE EVEN THE SILLY ONES
Contact Information

- Medicaid Eligibility Inbox
  - Medicaid.Eligibility@hcpf.state.co.us