* Forms to be completed for Adult Disability Programs*

Form 177: Non-Medical Evaluation of Disability: This form is used by the Disability Determination Unit to determine medical eligibility for the program you have applied for and must be filled out completely. Please answer all questions. If a question does not apply, please write N/A.

Form 900 (s): Authorization for Release of Protected Health Information: This form authorizes the Disability Determination Unit to contact your medical providers to obtain your medical information. Please fill out one form for each facility where you are currently receiving or have received treatment or services in the **past 2 years**.

- Please complete all sections. You will need to complete one form for each provider listed on Form 177, e.g. Hospitals, Facilities, Doctors, Schools and, Mental Health Agencies.
- Please make sure to address each question asked on number 2 and 3 of the form.
- You need to sign your name, and date this form.
- If you are a Legal Representative signing this form, copies of applicable documentation for the Legal Representative's authority **MUST** be attached.

Form 770: Reimbursement Agreement and Acknowledgement: If you are applying for financial assistance, either you or your Power of Attorney must complete this form and have it NOTARIZED. Failure to sign the form will result in denial for financial assistance. Please be sure your signature is legible.

Please note: If you own property or obtain property while receiving assistance, the State of N.H. will place a lien on your property within 30 days of the date that financial assistance begins. The State of NH will not seek collection on the lien as long as you or your surviving spouse resides on the property as the lawful owners.
If you are applying for medical assistance only, upon your death the State of N.H. will place a lien on your property for reimbursement of any medical assistance you received from age 55 and older. However, if you have a surviving spouse the lien would not be placed until after his/her death. If you receive medical assistance and you refused to sign the form the lien will still be placed.

ALL OF THE ATTACHED FORMS MUST BE RETURNED TO YOUR DISTRICT OFFICE BY:

- Mailing them using our self-addressed postage paid envelope
- Mail directly to :

  Centralized Scanning Unit (CSU)
  PO Box 181
  Concord, NH 03301

- Uploading them to your NH Easy account @ nheasy.nh.gov
- Drop them off in person at your local District Office

NON–MEDICAL EVALUATION OF DISABILITY

Initial ☐ Review ☐

Family Services Specialist: ______________________

Application Date: ______________________

TDD Access: Relay NH 1-800-735-2964

District Office: ______________________

PERSONAL INFORMATION:

Name (First, Middle & Last): ______________________

Sex Assigned at Birth: Male ☐ Female ☐

Date of Birth (Month, Day, Year): _______/_______/_______

Social Security Number: ________/_______/________

List any other names that you may have used on your medical records, such as maiden name, previous married name, etc.:______________________

Household Residence Address		**Household Mailing Address**	
Street Address:	______________________	Street / PO Box Address:	______________________
City/Town: ______________	Zip: ________	City/Town: ______________	Zip: ________

Daytime Telephone Number:

(If you have no phone number where you can be reached, give us a daytime number where we can leave a message.)

( ) ______________________ Your Number ☐ Message Number ☐ None ☐
Area Code Number

Email Address : ______________________

Can you **speak and understand English**? Yes ☐ or No ☐ **If NO**, what is your preferred language? ______________

Can you **read and understand English**? Yes ☐ No ☐

Can you **write more than your name in English**? Yes ☐ No ☐

If you cannot speak and understand English, is there someone over the age of 18 we may contact who speaks and understands English and will give you messages? Yes ☐ No ☐ (If "YES," complete the following information)

Name	Relationship	Daytime Phone

Have you applied for Social Security Disability Benefits (SSDI)? Yes ☐ No ☐ If yes, date applied (Month/Year): ____/____

If "YES", is your application: ☐ Pending ☐ Approved ☐ Denied ☐ Scheduled for an Evaluation/Exam

Have you applied for Supplemental Security Income (SSI)? Yes ☐ No ☐ If yes, date applied (Month/Year): _____/_____

If "YES", is your application: ☐ Pending ☐ Approved ☐ Denied ☐ Scheduled for an Evaluation/Exam

ABILITY TO WORK:

List all of the physical or mental illnesses, injuries and conditions (including emotional or learning problems) that limit your ability to work. If you have cancer, please include the stage and type. List each condition separately.

1. ______________________ 2. ______________________

3. ______________________ 4. ______________________

5. ______________________ 6. ______________________

7. ______________________ 8. ______________________

If you need more space, please provide on a separate sheet

Do your illnesses, injuries or conditions cause you **pain**? Yes ☐ No ☐

How do your illnesses, injuries or conditions limit or impact your ability to work: (check all that apply and explain below)

☐ Work fewer hours
☐ Change your job duties
☐ Make job-related changes such as attendance, help needed, or employers?

Explain: ____

____

Are you working now? Yes ☐ No ☐ **If NO,** when did you stop working? (month/day/year) ____/____/____

Why did you stop working? Explain: ____

____

EDUCATION AND TRAINING:

Check the highest grade of school **completed**. (Select 12, if you have education equivalent to high school from another country.)

Grade School: 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐

High School: 9 ☐ 10 ☐ 11 ☐ 12 ☐ GED ☐

College: 1 ☐ 2 ☐ 3 ☐ 4 + ☐

Date completed: (Month, Year) _____/ _____ ☐ I am still in school. (If still in school please indicate below).

Name of school: ______________________ Address (City, State): ______________________

Did/Do you attend **special education** classes? Yes ☐ No ☐ Did/Do you have an IEP? Yes ☐ No ☐

Have you completed any type of **special job training, trade or vocational school**? Yes ☐ No ☐

If "YES," what type? ______________________ Date completed (month/year): _____/ _____

VOCATIONAL REHABILITATION:

Are you receiving vocational rehabilitation services? Yes ☐ No ☐

Have you received these services in the past? Yes ☐ No ☐ If 'Yes" when? ______________________________

Name of agency: ______________________________

City/town where you received vocational rehabilitation services: ______________________________

NOTE: If you answered yes above, you will need to complete:

***DDU form 900 "Authorization for Release of Protected Health Information"* for the vocational agency.**

EMPLOYMENT HISTORY:

List all of the jobs that you have had in the **past 15 years** before you became unable to work or limited in your ability to work because of your physical or mental conditions including current employment. List the most recent first.

Or check this box if you have **not worked** in the past 15 years ☐.

Job Title (Example, Cashier)	**Type of Business** (Example, Department Store)	**Dates Worked**		**Hours worked each day**	**# of Days worked each week**	**Rate of Pay**
		From (month & year)	**To** (month & year)			(Per hour)
						$
						$
						$
						$
						$
						$
						$
						$
						$
						$

Did you receive accommodations at any of these jobs? Yes ☐ No ☐

If "yes" please explain which job, what the accommodations where and who may have assisted you (co-worker, or name of agency):______________________________

____

____

____

____

____

____

MEDICAL TREATMENT:

Tell us who may have medical records or other information about your illnesses, injuries or conditions for the **past two years**. This includes doctors' office, hospitals (including emergency room visits), clinics, mental health agencies, schools, and other health care facilities.

NOTE: For each facility listed, you will need to complete:
***DDU form 900 "Authorization for Release of Protected Health Information"*.**

Name of facility, practice or office			Date of First Visit (Month/Year)
Street address			
City	State	Zip Code	Date of Last Visit (Month/Year)
Phone Area Code ( ) Phone Number			
Reason(s) for visit			
If this was a hospital visit was it an ☐ Inpatient Stay ☐Outpatient Visit ☐ Emergency Room Visit			
Name of healthcare professional(s) who treated you			

Name of facility, practice or office			Date of First Visit (Month/Year)
Street address			
City	State	Zip Code	Date of Last Visit (Month/Year)
Phone Area Code ( ) Phone Number			
Reason(s) for visit			
If this was a hospital visit was it an ☐ Inpatient Stay ☐Outpatient Visit ☐ Emergency Room Visit			
Name of healthcare professional(s) who treated you			

Name of facility, practice or office			Date of First Visit (Month/Year)
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City	State	Zip Code	Date of Last Visit (Month/Year)

Phone Area Code ( ) Phone Number	
Reason(s) for visit	
If this was a hospital visit was it an ☐ Inpatient Stay ☐Outpatient Visit ☐ Emergency Room Visit	
Name of healthcare professional(s) who treated you	

Name of facility, practice or office			Date of First Visit (Month/Year)
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City	State	Zip Code	Date of Last Visit (Month/Year)
Phone Area Code ( ) Phone Number			
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Name of facility, practice or office			Date of First Visit (Month/Year)
Street address			
City	State	Zip Code	Date of Last Visit (Month/Year)
Phone Area Code ( ) Phone Number			
Reason(s) for visit			
If this was a hospital visit was it an ☐ Inpatient Stay ☐Outpatient Visit ☐ Emergency Room Visit			
Name of healthcare professional(s) who treated you			

Do you **currently take any medication** for your illnesses, injuries or conditions? Yes ☐ No ☐

If YES, tell us the following information: (If needed, look at your medicine bottles)

Name of Medicine	Doctor who ordered the medication	Reason for Medication

Have you sought financial help with getting your medications? Yes ☐ No ☐

Fill in the information below if you have **had, or are scheduled for**, any of the following medical tests.
NOTE: For each facility listed, you will need to complete DDU form 900 "Authorization for Release of Protected Health Information".

Type of Test	Date test was done or will be done	Name of place the test was done or will be done
EKG (Heart Test)		
Biopsy—Name of Body part(s) :		
Hearing Test		
Vision Test		
Psychiatric Evaluation		
IQ Testing		
Breathing Tests		
X-Ray—Name of body part(s) :		

MRI—Name of body part(s) :		
CT Scan—Name of body part(s) :		

The information on this form will be used to determine whether your condition impairs your ability to perform work or services and to establish the duration of your disability. It is important that you have answered every question. The information you give us on this form, in combination with medical information that we get from your doctors and therapists, will determine if you meet the medical criteria for the NH Medicaid program you requested. Please submit any medical records you have with this application.

Please add any additional comments that you think would help us in making a decision regarding your disability:

____
____
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(USE EXTRA PAPER IF NEEDED)

I hereby certify under penalty of unsworn falsification pursuant to RSA 641:3 that I understand all statements made, and that the information given on this form is true and complete to the best of my knowledge. I also understand that if I deliberately give false information or withhold information related to my situation, now or in the future, I am liable for prosecution for fraud.

______________________________ ______________________
Signature of Applicant Date

☐ I completed this form by myself ☐ I had help completing this form

______________________________ ______________________
Signature of person who helped complete this form Date

____
Relationship to applicant

ALL QUESTIONS MUST BE ANSWERED. AN INCOMPLETE FORM WILL NOT BE ACCEPTED.

Please return the completed forms to your local District Office.