



## Medical Exam Payment Authorization

Date:

Re:

CBMS #:

Eligibility Specialist

The above individual has applied for, or is receiving, Aid to the Needy Disabled (AND) through the Department of Social Services. In order to establish eligibility or redetermination eligibility for this program, it is necessary to determine if this person had a mental or physical impairment that would preclude him or her from engaging in employment.

The attached form (Med-9) has been designed to obtain the required medical information needed to make a determination of eligibility. Your assistance in completing the form is requested in order that we may make the correct eligibility determination. Please complete all of the sections of the form. If they are not completed, it may be necessary to deny or discontinue this person from assistance. If you have any questions or need assistance with the form, please contact me.

If it is necessary to perform an examination to complete this form and if Medicaid or insurance cannot be billed for the services, the Boulder County Department of Housing and Human Services will pay up to \$75.00. PLEASE COMPLETE AND SUBMIT THE INVOICE BELOW:

Invoice # (    ).

Please pay the following examining Physician's services:

Date:	Amount \$75.00
Patient Name:	
Doctor's Signature:	
Payee Name:	
Payee Address:	
Tax ID #:	
Technician's Signature of Approval:	



**COLORADO DEPARTMENT OF HUMAN SERVICES MED-9 FORM** The Aid to the Needy Disabled (AND) program provides financial benefits to Colorado residents who are disabled. This form is used by County Departments of Human Services to determine medical eligibility for the AND program. **Medical Personnel must complete the red section (Section 2).**

<b>Section 1</b>	<b>County</b>	Name (Last, First, Middle)	Social Security Number	Date of Birth
		Address	City, State, Zip Code	Client Telephone Number
		Printed Name of County Representative	County Telephone Number/FAX number 303-441-1000/303-441-1523	County BOULDER

<b>Section 2</b>	<b>Completed by the Medical examiner:</b>	<b>CHECK ONE</b>	<input type="checkbox"/> (If this box is checked, please also select the qualifying disability- more than 1 may be selected)	1. I find this individual has been or will be totally and permanently disabled to the extent they are unable to work full time at any job due to a physical or mental impairment. This disability is expected to last 12 months or more. <b>Select the Qualifying Disability:</b> <input type="checkbox"/> Respiratory disorders, such as cystic fibrosis, chronic persistent lung infections, or chronic pulmonary insufficiency; <input type="checkbox"/> Cardiovascular disorders, such as chronic heart failure despite medication, congenital heart disease, or recurrent arrhythmias not related to a reversible cause; <input type="checkbox"/> Digestive disorders, such as liver dysfunction or gastrointestinal hemorrhage; <input type="checkbox"/> Genitourinary disorders, such as chronic renal failure resulting in chronic hemodialysis; <input type="checkbox"/> Hematological disorders, such as sickle-cell disease, hemophilia, or aplastic anemia; <input type="checkbox"/> Congenital disorders, such as fragile X syndrome or phenylketonuria (PKU); <input type="checkbox"/> Neurological disorders, such as multiple sclerosis, muscular dystrophy, head trauma, or cerebral palsy; <input type="checkbox"/> Disorders of speech or other senses, such as blindness, tinnitus in combination with progressive hearing loss, or loss of speech; <input type="checkbox"/> Musculoskeletal disorders, such as a gross anatomical deformity, spinal stenosis or other spinal disorder resulting in nerve root compression, or amputation of both hands; <input type="checkbox"/> Mental or cognitive disorders, such as schizophrenia, affective disorders, personality disorders, developmental disabilities, or substance abuse to the extent that the disorder results in at least two of the following activities: -Marked restriction of activities of daily living; -Marked difficulties in maintaining social functioning; -Marked difficulties in maintaining concentration or pace; -Repeated decompensation for extended periods. <input type="checkbox"/> Other (please define): _____
			<input type="checkbox"/>	2. I find this individual is <b>not</b> totally disabled but does have a physical or mental impairment that substantially precludes this person from engaging in his/her usual occupation. This condition has been or will be for a period of (check one): <input type="checkbox"/> 6 months <input type="checkbox"/> 7 months <input type="checkbox"/> 8 months <input type="checkbox"/> 9 months <input type="checkbox"/> 10 months <input type="checkbox"/> 11 months <input type="checkbox"/> 12 months Physical exertion is limited to (check all that apply): <input type="checkbox"/> light <input type="checkbox"/> sedentary <input type="checkbox"/> moderate Please identify the less severe conditions preventing the individual from employment: _____
			<input type="checkbox"/>	3. I find this individual <b>does not</b> have a total physical or mental impairment that has lasted or is expected to last 6 months.
			<input type="checkbox"/>	4. PRIMARY DIAGNOSIS IS ALCOHOLISM OR CONTROLLED SUBSTANCE ADDICTION Checking this box means there is no other physical or mental disability(ies) that precludes this person from working other than his/her <b>alcohol or controlled substance addiction</b> . (If this box is checked, the individual will be offered treatment through ADAD and will be expected to work once treatment is complete.)

**If this is a Medical Re-examination, please answer this question if number 2 above was checked**

Yes  No Has there been improvement in this client's physical/mental condition that would allow the client to return to work?

This form may be completed by the following: (Please check one)

- Examining physician       Physician assistant certified in Colo.
- Psychiatrist                 Advanced practice nurse
- Registered nurse licensed in Colorado

**PRINTED NAME, ADDRESS, AND PHONE NUMBER.**

This is needed to insure the accuracy of this report

SIGNATURE:

STATE

LICENSE #

DATE OF EXAM

<b>Section 3</b>	<b>Applicant</b>	<b>Applicant Complete this yellow section before your medical exam:</b>	
		Highest Grade Completed:	Your age:
		Type of formal job training:	
		Explanation of disability or, if this is a redetermination, explain your progress since last medical examination:	

<b>Section 4</b>	<b>Supervisor</b>	The physical/mental impairment (Box 2, Section 2 above) and other factors such as: Age, Training, Experience, or Education would render the person totally disabled from having any employment that exists in the community for which they have competence. County must complete the Residual Functional Capacity Scoring Matrix below and document limitations in the case comments.	
			Signature of County Eligibility Supervisor/Supervisor Designee (Date)

RESIDUAL FUNCTIONAL CAPACITY SCORING MATRIX					
	Score Zero (0) Points	Score One (1) Point	Score Two (2) Points	Score Three (3) Points	Points
Age (in years)	18-30	31-49	50-54	55-59	
Education	GED, high school diploma, or higher	7 <sup>th</sup> through 11 <sup>th</sup> grade	6 <sup>th</sup> grade or less	Illiterate	
Communication Barriers	None	Mild	Moderate	Severe or Non-English Speaking	
Previous Work History	Skilled	Semi-Skilled	Unskilled	None	
Limitations Related to the Ability to: • Understand, • Remember, • Carry Out Instructions	None	Mild	Moderate	Severe	
Limitations related to the Ability to: • Use Judgment, • Concentrate, or • Respond Appropriately in a Work Environment	None	Mild	Moderate	Severe	
Medical disability results as reported on medical certification form, a Medicaid disability determination, or other medical evidence obtained by the county department	Disabled less than six (6) months. The client is ineligible for AND-SO.	Disabled six (6) months or longer but able to work in some type of employment. Physical exertion limited to sedentary, light, or moderate.	Disabled six (6) months or longer but able to work in some type of employment. Physical exertion limited to light or sedentary.	Disabled twelve (12) months or longer but able to work in some type of employment. Physical exertion limited to light or sedentary.	
<b>TOTAL RESIDUAL FUNCTIONAL CAPACITY SCORE</b> (maximum points possible = 21)					