LDSS-486T (6/12) **Attachment I**

MEDICAL REPORT FOR DETERMINATION OF DISABILITY

NEW YORK STATE DEPARTMENT OF HEALTH

SECTION I – IDENTIFICATION (To Be Completed by Submitting Agency)

AGENCY'S NAME AND ADDRESS:	PATIENT'S NAME *(Last, First, Middle)*:	CASE NUMBER:	
WNY Coalition Pooled Trust	PATIENT'S ADDRESS *(Street, City, State & Zip Code)*:	SOCIAL SECURITY NUMBER:	
		SEX: ☐ MALE ☐ FEMALE	DATE OF BIRTH:

SECTION II – MEDICAL REPORT – NOTICE TO PHYSICIAN

This individual has made an application (reapplication) for Disability Medicaid. Your cooperation in completing this form to show the individual's current condition, focusing on both remaining capabilities and limitations, is requested. Your promptness will ensure an early decision on the individual's application.

Please return the completed form to the agency in Section I above.

Diagnosis(es):

Date of last exam: ____________________

Height: ____ **ft.** ____ **in.**

Weight: _______ **lbs.**

Exertional Functions. Please indicate what the individual is CAPABLE of doing:

Lifting:	**Carrying:**	**Standing:**	**Walking:**	**Sitting:**	**Pushing:**	**Pulling:**
☐ < 10 lbs.	☐ < 10 lbs.	☐ < 2 hrs./day	☐ < 2 hrs./day	☐ < 6 hrs./day	☐ Using R arm	☐ Using R arm
☐ Max. 10 lbs.	☐ Max. 10 lbs.	☐ 2 hrs./day	☐ 2 hrs./day	☐ 6 hrs./day	☐ Using L arm	☐ Using L arm
☐ Max. 20 lbs./freq. 10 lbs.	☐ Max. 20 lbs./freq. 10 lbs.	☐ 6 hrs./day	☐ 6 hrs./day		☐ Using R leg	
☐ Max. 50 lbs./freq. 25 lbs.	☐ Max. 50 lbs./freq. 25 lbs.				☐ Using L leg	
☐ > 50 lbs.	☐ > 50 lbs.					

Non-Exertional Functions. Please check if LIMITATIONS exist in any of the areas below:

Sensory: ☐ No Limitations
- ☐ Seeing
- ☐ Hearing
- ☐ Speaking

Postural: ☐ No Limitations
- ☐ Stooping/Bending
- ☐ Crouching/Squatting
- ☐ Climbing

Manipulative: ☐ No Limitations
- ☐ R Upper Extremity
- ☐ L Upper Extremity

Environmental: ☐ No Limitations
- ☐ Tolerating dust, fumes, extremes of temperature
- ☐ Tolerating exposure to heights or machinery
- ☐ Operating a motor vehicle

Mental: ☐ No Limitations
- ☐ Understanding, carrying out, remembering instructions
- ☐ Making simple work-related decisions
- ☐ Responding appropriately to supervision, co-workers, work situations
- ☐ Dealing with changes in a routine work setting

Signature of Physician:	**(Print Name):**	**Date Signed:**
Specialty:	**Office Address:**	**Office Phone Number:**