NEW YORK STATE DEPARTMENT OF HEALTH
Disability Review Unit

Medical Report for Determination of Disability

Section I – Identification

Agency
State Disability Review Unit OCP-826
State of New York
Department of Health
Albany, NY 12237
Telephone Number: 1(866) 330-0591

Patient
Name (Last, First, Middle) _____

Address (Street, City, State & Zip Code): _____

Date of Birth ___/___/___

Sex ☐ Male ☐ Female

Case Number _____

Client ID Number _____

Disability ID Number _____

SSN (last four digits) _____

Section I – Medical Report – Note to Provider

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, along with a copy of all medical records for the past 12 months.

Diagnosis(es) _____

Date of last exam _____

Height _____ ft. _____ in.

Weight _____ lbs.

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

Lifting
☐ < 10 lbs.
☐ Max. 10 lbs.
☐ Max. 20 lbs./freq. 10 lbs.
☐ Max. 50 lbs./freq. 25 lbs.
☐ > 50 lbs.

Carrying
☐ < 10 lbs.
☐ Max. 10 lbs.
☐ Max. 20 lbs./freq. 10 lbs.
☐ Max. 50 lbs./freq. 25 lbs.
☐ > 50 lbs.

Standing
☐ < 2 hrs./day
☐ 2 hrs./day
☐ 6 hrs./day

Walking
☐ < 2 hrs./day
☐ 2 hrs./day
☐ 6 hrs./day

Sitting
☐ < 6 hrs./day
☐ 6 hrs./day

Pushing
☐ Using R arm
☐ Using L arm
☐ Using R leg
☐ Using L leg

Pulling
☐ Using R arm
☐ Using L arm

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

Provider Signature _____

Print Name _____

Date Signed _____

Specialty _____

Office Address _____

Office Phone Number _____

PLEASE RETURN THIS FORM **ALONG WITH A COPY OF ALL MEDICAL RECORDS FOR THE PAST 12 MONTHS.**