AHCCCS
Arizona Health Care Cost Containment System

Disability Report

CUSTOMER:	DATE:	HEAPLUS PERSON ID:	APPLICATION ID:

PLEASE PRINT, TYPE, OR WRITE CLEARLY AND ANSWER ALL ITEMS THE BEST YOU CAN. If you are filing on behalf of someone else, enter his or her name and Social Security number in the space provided and answer all questions. **COMPLETE ANSWERS WILL HELP IN PROCESSING THE CLAIM**.

PRIVACY ACT NOTICE: The information requested on this form is authorized by Title 20 CFR 404.1512 and Title 20 CFR 416.912. The information provided will be used in making a decision on this claim. While completion of this form is voluntary, if you do not give us the information asked for, it could take us longer to make a decision. We may give information you give us on this form to another person or government agency only with respect to AHCCCS programs and to comply with Federal laws requiring the exchange of information between AHCCCS and another agency.

Name of applicant	Social Security Number	Date of Birth

Telephone number where applicant can be reached	Best time to reach applicant

Does the applicant speak English?	☐ YES ☐ NO

If **NO**, what language does the applicant speak?

If an agency or organization (such as a Regional Behavioral Health Authority provider) helped the applicant complete the application, please provide the following information.

Name of Agency or Organization providing assistance

Name of Contact person	Best time to reach contact person

Phone number	Fax number	Email Address

Does the applicant need assistance in processing his/her claim? If **YES**, please enter the following information	☐ YES ☐ NO

Name of person providing assistance	Relationship of person providing assistance

Address of person providing assistance	

Telephone number of person providing assistance	Best time to reach person providing assistance

Reason the applicant requires assistance

CUSTOMER:	DATE:	HEAPLUS PERSON ID:	APPLICATION ID:

What is the applicant's medical condition? (Briefly explain the injury or illness that stopped the applicant from working).	
When did this medical condition begin?	

Does the applicant have:

End Stage Renal Disease ☐ YES ☐ NO

Kidney Disease or Failure ☐ YES ☐ NO

Acute Leukemia ☐ YES ☐ NO

If the applicant did not answer '**yes**' to one or more of the questions above, does the applicant have one of the severe disabilities listed at https://www.ssa.gov/compassionateallowances/conditions.htm

☐ YES ☐NO If '**yes**', describe the condition

If **YES**, complete pages 1, 4 & 10 only. If NO, complete all pages of this form.

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PART I – INFORMATION ABOUT MEDICAL RECORDS

1. List the name, address, and telephone number of the doctor or clinic that has the applicant's latest medical records	☐ Check here if the applicant has no doctor
Name of Doctor/Name of Clinic	Address
Telephone Number (including area code)	

How often does the applicant see this doctor or clinic?	Date the applicant first saw this doctor or clinic (mm/dd/yyyy)	Date the applicant last saw this doctor or clinic (mm/dd/yyyy)

Reasons for visits (medical condition for which applicant had an examination or treatment)

Type of treatment (such as surgery, chemotherapy and radiation, if known). If no treatment, write "**NONE**".

2a. Has the applicant seen any other doctor(s) or clinics since this medical condition began? If **YES**, give the following	☐ YES ☐ NO
Name of Doctor/Name of Clinic	Address
Telephone Number (including area code)	

How often does the applicant see this doctor or clinic?	Date the applicant first saw this doctor or clinic (mm/dd/yyyy)	Date the applicant last saw this doctor or clinic (mm/dd/yyyy)

Reasons for visits (medical condition for which applicant had an examination or treatment)

Type of treatment (such as surgery, chemotherapy and radiation, if known). If no treatment, write "**NONE**".

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2b. Identify below any other doctor or clinic the applicant has seen since this medical condition began.		
Name of Doctor/Name of Clinic	Address	
Telephone Number (including area code)		
How often does the applicant see this doctor or clinic?	Date the applicant first saw this doctor or clinic (mm/dd/yyyy)	Date the applicant last saw this doctor or clinic (mm/dd/yyyy)
Reasons for visits (medical condition for which applicant had an examination or treatment)		
Type of treatment (such as surgery, chemotherapy and radiation, if known). If no treatment, write "**NONE**".		

2c. Identify below any other doctor or clinic the applicant has seen since this medical condition began.		
Name of Doctor/Name of Clinic	Address	
Telephone Number (including area code)		
How often does the applicant see this doctor or clinic?	Date the applicant first saw this doctor or clinic (mm/dd/yyyy)	Date the applicant last saw this doctor or clinic (mm/dd/yyyy)
Reasons for visits (medical condition for which applicant had an examination or treatment)		

CUSTOMER:	DATE:	HEAPLUS PERSON ID:	APPLICATION ID:

Type of treatment (such as surgery, chemotherapy and radiation, if known). If no treatment, write "**NONE**".
If applicant has seen other doctors or clinics since this medical condition began, list their names, addresses, dates and reasons for visits in **Part V**.

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3a. Has the applicant been hospitalized for this medical condition? If **YES**, give the following:	☐ YES ☐ NO
Name of Hospital	Phone Number
Patient Number	

Was the applicant an inpatient (i.e. stayed at least overnight)? ☐ YES ☐ NO If **YES**, give the following:		Was the applicant an outpatient? ☐ YES ☐ NO If **YES**, give the following:
Date(s) of Admission(s)	Date(s) of Discharge(s)	Date(s) of Visit(s)

Reason for hospitalization (medical condition for which the applicant had an examination or treatment)

Type of treatment (such as surgery, chemotherapy and radiation, if known). If no treatment, write "**NONE**".

3b. If the applicant has been in another hospital for this medical condition, list it below:	
Name of Hospital	Phone Number
Patient Number	

Was the applicant an inpatient (i.e. stayed at least overnight)? ☐ YES ☐ NO If **YES**, give the following:		Was the applicant an outpatient? ☐ YES ☐ NO If **YES**, give the following:
Date(s) of Admission(s)	Date(s) of Discharge(s)	Date(s) of Visit(s)

CUSTOMER:	DATE:	HEAPLUS PERSON ID:	APPLICATION ID:

Reason for Hospitalization (medical condition for which the applicant had an examination or treatment)
Type of treatment (such as surgery, chemotherapy and radiation, if known). If no treatment, write "**NONE**".

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4. Has the applicant been seen by other agencies for this medical condition? (VA, worker's compensation, mental health agencies, vocational rehabilitation services, etc.). If **YES**, fill in the information below:	☐ YES ☐ NO
Name of Agency	Agency Phone Number Agency Address
Applicant Claim Number	
Dates of visits(mm/dd/yyyy)	Types of treatments or examination received
If more space is needed, list the other agencies, their address, applicant's claim numbers, dates, and treatment received in Part V.	

5. Has the applicant had any of the following tests in the last year?

		If **YES**, state:	
TEST	**YES / NO**	**Where Done**	**When Done**
Electrocardiogram	☐ YES ☐ NO		
Chest X-ray	☐ YES ☐ NO		
Other X-ray (name body part here)	☐ YES ☐ NO		
Breathing Tests	☐ YES ☐ NO		
Blood Tests	☐ YES ☐ NO		
Other (specify)	☐ YES ☐ NO		
Other (specify)	☐ YES ☐ NO		

6. If the applicant has an AHCCCS card, what is the ID number (some hospitals and clinics file records by the AHCCCS number)?

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7. List all medications that the applicant currently takes:

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PART II – INFORMATION ABOUT YOUR ACTIVITIES

1. Has any doctor told the applicant to cut back or limit activities in any way? ☐ YES ☐ NO
If **YES**, give the name of the doctor below and tell us what he/she told the applicant.

2. Describe applicant's daily activities (example: walking – 1 block or 10 minutes throughout the day).

- **HOUSEHOLD ACTIVITIES** (including cooking, cleaning, shopping, and odd jobs around the house as well as any other similar activities):

	Activity	How Much	How Often	Help Needed
1				
2				
3				
4				
5				

- **RECREATIONAL ACTIVITIES AND HOBBIES** (hunting, fishing, bowling, hiking, musical instruments, etc):

	Activity	How Much	How Often	Help Needed
1				
2				
3				
4				
5				

- **SOCIAL CONTACTS** (visits with friends, relatives, neighbors):

	Activity	How Much	How Often	Help Needed
1				
2				
3				
4				
5				

- **OTHER** (drive car, motorcycle, ride bus, etc):

	Activity	How Much	How Often	Help Needed
1				
2				
3				
4				
5				

CUSTOMER:	DATE:	HEAPLUS PERSON ID:	APPLICATION ID:

PART III – INFORMATION ABOUT YOUR EDUCATION

1. What is the highest grade of school the applicant completed?	Month/Year Completed?

Has the applicant attended trade or vocational school or had any type of special training?

☐ YES ☐ NO

If **YES**, describe:

- The type of trade or vocational school or training:

_____

–

- Approximate dates the applicant attended:

_____

–

- How this schooling or training was used in any work applicant did.

_____

–

PART IV – INFORMATION ABOUT THE WORK YOU DID

1. When did the applicant's medical condition first bother the applicant?	Month	Day	Year

2a. Did the applicant work after the date shown in item 1? (If **NO**, go to items 3A and 3B).	☐ YES ☐ NO

2b. If the applicant did work since the date in item 1, did the medical condition cause the applicant to change:

Job or job duties?	☐ YES ☐ NO
Work hours?	☐ YES ☐ NO
Attendance?	☐ YES ☐ NO
Anything else about the job?	☐ YES ☐ NO

If the applicant answered **NO** to ALL of these, go to items 3a and 3b.

2c. If the applicant answered YES to any item in 2b, explain below the changes in the job, the dates they happened, and how the medical condition made these changes necessary.

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3a. When did the medical condition finally make the applicant stop working?	Month	Day	Year

3b. Explain how the medical condition keeps the applicant from working now.

4. List all jobs the applicant has had in the last 15 years. If you need more space, use Part V or attach a separate piece of paper.

Job Title	Type of Business	Dates Worked (Month/Year)		Days Per Week	Rate of Pay (per hour, day, week, month or year)
		FROM	TO		

5a. For the job the applicant did the longest, describe the basic duties (explain what the applicant did and how it was done).

5b. Provide the following information for the job the applicant did the longest.
In the job did the applicant:

- Use machines, tools, or equipment of any kind? ☐ YES ☐ NO
  If **YES**, what did the applicant use?
  _____
- Use technical knowledge or skills? ☐ YES ☐ NO
  If yes, what technical knowledge or skills were involved?

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- Do any writing, complete reports, or perform similar duties? ☐ YES ☐ NO

  If yes, what type of writing did the applicant do?

  _____

- Have supervisory responsibilities? ☐ YES ☐ NO

  If yes, how many people did the applicant supervise and what were the duties?

  _____

5c. Describe the kind and amount of physical activity during a normal day for the job worked the longest:

• **WALKING** (check the number of hours a day spent walking	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8
• **STANDING** (check the number of hours a day spent standing)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8
• **SITTING** (check the number of hours a day spent sitting)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8

• **BENDING** (check how often a day the applicant had to bend)

☐ Never ☐ Occasionally ☐ Frequently ☐ Constantly

• **REACHING** (check how often a day the applicant had to reach)

☐ Never ☐ Occasionally ☐ Frequently ☐ Constantly

• **LIFTING AND CARRYING:** Describe below what the applicant lifted, and how far the applicant carried it. Check heaviest weight lifted below and weight frequently lifted and/or carried:

HEAVIEST WEIGHT LIFTED	**WEIGHT FREQUENTLY LIFTED/CARRIED**
☐ **10 lbs**	☐ **Up to 10 lbs**
☐ **20 lbs**	☐ **Up to 20 lbs**
☐ **50 lbs**	☐ **Up to 50 lbs**
☐ **100 lbs**	☐ **Over 50 lbs**
☐ **Over 100 lbs**	

PART V – REMARKS/APPLICANT INFORMATION

CUSTOMER:	DATE:	HEAPLUS PERSON ID:	APPLICATION ID:

Use this section to answer any previous questions or to give any additional information that you think will be helpful in making this decision. Please refer to the previous items by number. If you need more space, use a separate sheet of paper. You may attach any proof that shows the applicant's current medical condition.

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PART VI – AUTHORIZATION AND NOTIFICATION STATEMENTS

I declare under penalty of perjury under the laws of the State of Arizona that the information on this form is true and correct to the best of my knowledge.

- Copies of my medical records may be given to a physician or medical institution before I go for an independent medical examination if an examination is necessary.
- Results of my independent examination may be given to my personal physician.
- My medical information may be furnished to any contractor for transcription, typing, record copying, or other related clerical or administrative service performed for the State Disability Determination Services Administration.
- I agree to tell the AHCCCS Administration if my medical condition improves or I go to work.
- I know that anyone who does not tell the truth in an application commits a crime punishable under Federal law. I swear that the above statements are true.

Name (Signature of applicant or person filing on the applicant's behalf)	Date (mm/dd/yyyy)

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

1. Signature of Witness	2. Signature of Witness
Address (number and street, city, state, and zip code)	Address (number and street, city, state, and zip code)

PART VII – FOR AHCCCS USE ONLY – DO NOT WRITE BELOW THIS LINE

DE-121 Taken by:	Form Supplemented? ☐ YES ☐ NO
☐ Personal Interview ☐ Telephone ☐ Mail	If **Yes**, by: ☐ Personal Interview ☐ Telephone ☐ Mail

Signature of Benefits and Eligibility Specialist	Date (mm/dd/yyyy)

Local Office Address	Local Office Phone Number