

Presumptive Medical Disability Determination Telephone Consultation Guide

ES-3903
10-06

Applicant's Name: _____

Your application for benefits has been referred to our Case Development Team. **You must call the team for your application to be considered. Please call 1-800-xxxx on _____ at _____.**
(date) (time)

Before you call, complete as much of this worksheet as you can. Completing the worksheet will help you get ready for the telephone call. Be sure to call even if you cannot get all of the information. We will help you get any information that is missing. **Keep this worksheet with you during the call.**

The call will last about 30 to 40 minutes.

1. What illnesses, injuries or conditions limit your ability to work?

2. What date did you become unable to work because of your medical condition (month/day/year)?

3. List your doctor, therapist, or any other person who has treated you or who you expect to treat you in the future.

Name	Address, Zip Code, and Phone Number	Date First Seen	Date Last Seen

4. List the **hospitals, clinics, or emergency rooms** you visited or expect to visit.

Name	Address, Zip Code, and Phone Number	Date In	Date Out

5. List **medications** you take and **why** you take them. If **prescribed**, provide the **doctor's name**. **Have your medication bottles with you at the time of your call.**

Name of Medicine	Why you take it	Prescribed By

6. Medical tests you had or are going to have in the future. Examples of medical tests are EKG (heart test), treadmill (exercise test), biopsy (name body part biopsied), x-rays, etc.

Name of Test	Place of Test	Person who sent you	Date

7. List **jobs** you had in the 5 years before you became unable to work.

Job Title (e.g., cook)	Type of Business (e.g., restaurant)	Dates Worked (month/year) From - To	Hours Per Day	Days Per Week	Rate of Pay (per hour/ week /Year)

8. Circle the **highest grade** of school you completed.

1 2 3 4 5 6 7 8 9 10 11 12 GED College: 1 2 3 4 or more

Did you attend **special education** classes? Yes ____ No ____

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

If yes, type of training received _____

9. What does your **typical day look like**?

10. What were you able to do before your illnesses or conditions that you **cannot** do now?

11. Which of the following best describes **where you have lived during the past 6 months**. If you have lived in more than one location, please check each location that applies.

- Own home
- Rent home
- Live with relative(s)
- Live with friend(s)
- Shelter
- Section 8 or HUD Housing
- Homeless
- Other (please describe) _____

12. Of the services listed below, **what 3 do you need the most?** Place a 1 by the service that is the most important, place a 2 by the service that is the second most important, and place a 3 by the service that is third most important.

- A job
- Money
- Health Care
- Food Assistance/Food Stamps
- Housing
- Transportation
- Utility assistance
- Other (please describe) _____

13. **Why do you think you cannot work? Limit your answer to the top 3 reasons.** Place a 1 by the most important reason, a 2 by the second most important reason and a 3 by the third most important reason.

- Health problems
- Cannot find work
- Do not have the education or training needed
- Not enough work experience
- Lack of housing
- Lack of transportation
- Lack of necessities (clothing, personal products such as soap, shampoo, etc.)
- Other (please describe) _____

14. Do you have **public transportation** (e.g., buses) in your home area?

_____ Yes
_____ No

15. **How do you travel** around? Please check each one that you use.

_____ Own car
_____ Ride with a relative or friend
_____ Use public transportation
_____ Use special transportation (wheelchair van, etc.)
_____ Ride bicycle
_____ Walk
_____ Other (please describe) _____

16. Did you have any **health insurance before** applying with SRS?

_____ Yes
_____ No

17. **If you answered yes** to question number 16.

a) when did you last have the health insurance? _____ (month/year)
b) what was the name of the health insurance? _____

18. Have you ever received **services** in a **mental health hospital**?

_____ Yes
_____ No

If yes, what is the name of the mental health hospital(s)? _____

Date last admitted: _____ (month/year)

19. Have your ever received **services** in a **substance abuse facility**?

_____ Yes
_____ No

If yes, what is the name of the substance abuse facility(ies)? _____

Date last admitted: _____ (month/year)