

DISABILITY INTERVIEW

AGENCY

NEW YORK STATE		DEPARTMENT OF HEALTH	
A. NAME (Last, First, Middle)	B. SOCIAL SECURITY NUMBER	C. DATE OF BIRTH	D. TELEPHONE NUMBER ()
E. SSI/SSD DISABILITY HISTORY (Include Dates)		F. CASE NUMBER	H. MA/PA APPLICATION DATE
I. IMPAIRMENTS		J. CATEGORY AT REFERRAL	
		PUBLIC ASSISTANCE: <input type="checkbox"/> FNP MEDICAID <input type="checkbox"/> FP MEDICAID	
		MEDICAID ONLY: <input type="checkbox"/> FNP MEDICAID <input type="checkbox"/> FP MEDICAID	
		FS ONLY <input type="checkbox"/> OTHER <input type="checkbox"/> _____	
		K. AUDIT CASE <input type="checkbox"/> YES <input type="checkbox"/> NO	

PART I – INFORMATION ABOUT YOUR IMPAIRMENTS

1. WHEN DID YOUR IMPAIRMENTS FIRST BOTHER YOU? MONTH _____ DAY _____ YEAR _____	2. DID YOU WORK AFTER THE DATE SHOWN IN ITEM 1? <input type="checkbox"/> YES <input type="checkbox"/> NO	3. A. DID YOUR IMPAIRMENTS FINALLY CAUSE YOU TO STOP WORKING? IF SO, WHEN? MONTH _____ DAY _____ YEAR _____
3. B. DOES YOUR HEALTH AFFECT YOUR ABILITY TO WORK? (Please explain)		

PART II – INFORMATION ABOUT YOUR MEDICAL RECORDS

4. LIST THE NAME, ADDRESS AND TELEPHONE NUMBER OF THE PRIMARY PHYSICIAN WHO HAS MEDICAL RECORDS ABOUT YOUR IMPAIRMENTS.		IF YOU HAVE NO DOCTOR CHECK <input type="checkbox"/>
NAME	ADDRESS	
TELEPHONE NUMBER (Include Area Code) ()		
HOW OFTEN DO YOU SEE THIS DOCTOR?	DATE YOU FIRST SAW THIS DOCTOR.	DATE YOU LAST SAW THIS DOCTOR.
REASONS FOR VISITS (State illness or injury for which you had an examination or treatment.)		
TYPE OF TREATMENT OR MEDICINES RECEIVED (Such as surgery, chemotherapy, radiation, and the medicines including strength and dosage taken for your illness or injury. If no treatment or medicines, indicate "NONE".)		

5. HAVE YOU SEEN ANY OTHER DOCTORS FOR YOUR IMPAIRMENTS? YES NO

NAME	ADDRESS
TELEPHONE NUMBER (Include Area Code) ()	

HOW OFTEN DO YOU SEE THIS DOCTOR?	DATE YOU FIRST SAW THIS DOCTOR.	DATE YOU LAST SAW THIS DOCTOR.
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REASONS AND TREATMENT (If different than in 4 on the front of this form.)

6. HAVE YOU BEEN TREATED BY ANY OTHER DOCTORS FOR YOUR IMPAIRMENTS? YES NO (If YES, complete LDSS-1151.1 - Continuation Sheet)

7. HAVE YOU BEEN HOSPITALIZED OR TREATED AT A CLINIC FOR YOUR IMPAIRMENTS? YES NO

NAME OF HOSPITAL OR CLINIC	ADDRESS
PATIENT OR CLINIC NUMBER	
CONTACT PERSON	POSITION

WERE YOU AN INPATIENT? (Stayed at least overnight?) YES NO (If YES, indicate admission and discharge dates.)

WERE YOU AN OUTPATIENT? YES NO (If YES, indicate dates of visits.)

REASON FOR HOSPITALIZATION OR CLINIC VISITS (State illness or injury for which you had an examination or treatment.)

TYPE OF TREATMENT OR MEDICINES RECEIVED (Such as surgery, chemotherapy, radiation, and the medicines including strength and dosage taken for your illness or injury. If no treatment or medicines, indicate "NONE".)

8. HAVE YOU BEEN TREATED BY ANY OTHER HOSPITALS OR CLINICS FOR YOUR IMPAIRMENTS? YES NO (If YES, complete LDSS-1151.1 - Continuation Sheet)

9. HAVE YOU HAD ANY OF THE FOLLOWING TESTS IN THE LAST YEAR?

TEST	CHECK APPROPRIATE BLOCK OR BLOCKS	IF "YES" SHOW	
		WHERE DONE	WHEN DONE
Electrocardiogram	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Chest X-Ray	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Other X-Ray (Name body part here)	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Breathing Tests	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Blood Tests	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Other (Specify)	<input type="checkbox"/> YES <input type="checkbox"/> NO		

10. HAVE YOU BEEN SEEN BY OTHER AGENCIES FOR YOUR DISABLING IMPAIRMENTS? (VA, Worker's Compensation, Vocational Rehabilitation, etc.) YES NO

NAME OF AGENCY	ADDRESS
YOUR CLAIM NUMBER	
DATES OF VISITS	
CONTACT PERSON	POSITION

PART III - INFORMATION ABOUT YOUR ACTIVITIES

11. HAS YOUR DOCTOR TOLD YOU TO CUT BACK OR LIMIT YOUR ACTIVITIES IN ANY WAY? YES NO
 IF 'YES' GIVE THE NAME OF THE DOCTOR BELOW AND TELL WHAT HE OR SHE TOLD YOU ABOUT CUTTING BACK OR LIMITING ACTIVITIES.

12. DESCRIBE YOUR DAILY ACTIVITIES IN THE FOLLOWING AREAS AND STATE WHAT AND HOW MUCH YOU DO OF EACH AND HOW OFTEN YOU DO IT:

- Household Chores
- Recreational activities and hobbies
- Social contacts
- Other (any similar activities)

PART IV - INFORMATION ABOUT YOUR EDUCATION AND LITERACY

13. SCHOOLING				14. HIGHEST GRADE COMPLETED	15. AGE AT COMPLETION
<input type="checkbox"/> Elementary	<input type="checkbox"/> H.S.	<input type="checkbox"/> College	<input type="checkbox"/> Special Class or School		
16. ENGLISH			17. OTHER LANGUAGE(S)		
<input type="checkbox"/> Speak	<input type="checkbox"/> Read	<input type="checkbox"/> Write	<input type="checkbox"/> Speak	<input type="checkbox"/> Read	<input type="checkbox"/> Write Specify language _____
18. PROFESSIONAL OR VOCATIONAL TRAINING (Specify course of study, dates, degrees, certifications etc.)					

PART V - INFORMATION ABOUT THE WORK YOU DID IN PAST 15 YEARS

19. HAVE YOU WORKED IN THE PAST 15 YEARS? YES NO (If YES, complete Work History Below.)

JOB TITLE (Most Recent Job)	TYPE OF BUSINESS	DATES WORKED (Month & Year)		HOURS PER WEEK	RATE OF PAY (Per hour, day, week, month or year)	REASON FOR LEAVING
		FROM	TO			

DESCRIBE YOUR BASIC DUTIES:

DESCRIBE THE KIND AND AMOUNT OF PHYSICAL ACTIVITY THIS JOB INVOLVED DURING TYPICAL DAY IN TERMS OF:

- WALKING (Circle the number of hours a day spent walking) -- 0 1 2 3 4 5 6 7 8
- STANDING (Circle the number of hours a day spent standing) -- 0 1 2 3 4 5 6 7 8
- SITTING (Circle the number of hours a day spent sitting) -- 0 1 2 3 4 5 6 7 8
- BENDING (Circle how often a day you had to bend) -- Occasionally Frequently Constantly
- REACHING (Circle how often a day you had to reach) -- Occasionally Frequently Constantly
- LIFTING (Circle heaviest weight lifted) -- Less than 10 lbs., 10 lbs., 20 lbs., 50 lbs., 100 lbs. or more
 (Circle weight frequently lifted) -- Less than 10 lbs., 10 lbs., 25 lbs., 50 lbs. or more

