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:**	
	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	**Postural:** ☐ No Limitations	**Manipulative**: ☐ No Limitations
☐ Seeing	☐ Stooping/Bending	☐ R Upper Extremity
☐ Hearing	☐ Crouching/Squatting	☐ L Upper Extremity
☐ Speaking	☐ Climbing	

Environmental: ☐ No Limitations	**Mental:** ☐ No Limitations
☐ Tolerating dust, fumes, extremes of temperature	☐ Understanding, carrying out, remembering instructions
☐ Tolerating exposure to heights or machinery	☐ Making simple work-related decisions
☐ Operating a motor vehicle	☐ 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:**