

**Income Maintenance Caseworker's  
Guide To The Disability Determination Process**

**Medicaid Eligibility Section**

## I. Use Of This Guide

The Medicaid policy contained in MA-2303 and MA-2525 gives instructions for taking and processing disability applications. The purpose of this guide is to give the IMC additional information on interviewing disability applicants about their medical condition. The goal is to provide DDS with a Social History Summary that contains the most pertinent information so that disability determinations can be made more quickly. In addition to documenting the information in Attachment C, the IMC also needs to document observations on the DMA 5009.

## II. The IMC's Role in Disability Determination

### A. Interviewing Disability Applicants

In addition to explaining the M-AD program and obtaining information needed to determine eligibility with regard to income, resources, and other criteria, the IMC must also obtain information about the applicant's physical and/or mental condition that will be used by DDS examiners.

During the disability interview, the IMC must accurately record the applicant's comments about his disabling condition. This information will give the disability examiners a clear picture of how the applicant's disabling condition affects him.

This interview is usually the applicant's only opportunity to describe his disabling condition completely. Therefore, his "story" must be recorded in his own words. Often the applicant will find it difficult to express himself. The IMC must elicit responses that paint a clear picture of what the applicant is saying.

Allow the applicant to describe the effects (or symptoms) of the impairment in his own way by asking broad questions, such as "How does your condition limit your ability to work?" Since the IMC is the eyes and ears of the disability team, record any observations or effects the impairment has on the applicant.

Refer to Attachment A for a Disability Interview Guide, which gives examples of questions to ask for certain impairments. The information gathered by the IMC can help expedite the disability determination process when the case reaches DDS.

**NOTE:** The terms applicant/recipient and claimant are interchangeable terms.

### B. Documenting the Social History Summary (DMA-5009)

There are two attachments, Attachment B and C, which give detailed instructions concerning completion of this form. Attachment B has the instructions for completion of the form itself. Attachment C has background information about why each of the sections is important. It is recommended that every IMC who takes disability applications review these desk aids.

Collateral Information - DDS needs the contact information (name, address, telephone #, etc.) of the person giving the information. DDS also needs the name, address, and telephone # of someone who can provide information and someone who can act as a responsible party. (Note: That may be the same person or two different people.) The form requests this information if a mental impairment is alleged; this includes substance abuse. In addition, even if a mental impairment is not alleged, if a worker observes that a claimant might need assistance in following through for any reason, DDS needs this information. DDS prefers that a third party be listed on every application as it is on SSA claims. A worker usually has this information but just does not realize how important this is for DDS. In addition, if a claimant does not speak English, DDS needs the contact information for someone who does speak English.

Work Status/Medical Expenses – If a claimant is currently working, please ask him if he has incurred any impairment related work expenses. Certain disability related items and services (e.g., attendant care services, regularly prescribed medical treatment, therapy, or prescription medications, and some transportation services) that a person needs in order to work can be deducted from earnings in determining whether an individual is engaging in substantial gainful activity. There is not a question on the form specifically for this, but DDS must have this when investigating work history. DDS is only interested in treatment or devices for which he has paid out of pocket, not what he owes. It would be very helpful for counties to ask this since they are asking about resources anyway. It is also critical whether or not the individual works under special considerations, so asking something like “do you perform the job like everyone else?” would be very helpful. These issues are part of the DDS normal work investigation. DDS has experienced difficulty reaching many of these claimants after the application has been sent to DDS. It would be better to get some cursory information while he is sitting at DSS than have him disappear on us later.

School Information – Section III.C covers information about education (highest grade completed, etc.), but not current school enrollment. If the claimant is under 18, DDS must contact the current or last school for records. If the claimant is an adult but alleges a long-standing mental

problem, DDS also frequently has to contact the school systems for cumulative records. This information could be entered in Section II B. (daily activities), or III.C. (Education).

The following are general instructions related to the entire process or package submitted to DDS:

Medical Treatment (Section IV) – All providers of medical services or evaluations need to be listed. It is extremely important for DDS to know the date last seen and whether or not that provider is still seeing an applicant.

Medical Records – Any medical records in the DSS record or in the claimant's possession should be sent to DDS with the package or subsequent to the transmittal if received later. DSS routinely obtains records on non-qualified aliens for DMA; copies should be sent to DDS as well when disability must be established. Many claimants have medical records in their possession; they should be copied and sent to DDS.

Prior Files – Prior files from the past 12 months should be sent on all applications. Prior files from any date in the past should be sent on reviews. In addition, counties should also send copies of any state appeal decisions, especially on reviews.

Onset Date - Please be very specific in requesting retroactive coverage. Don't just ask for the generic three months if the retroactive months are not needed.

Dispositions that negate the need for a disability decision – When disposing of a case for a reason not related to disability, please notify DDS that a disability decision is no longer needed. The notification can be made by telephone or fax.

Release – An original DMA-5028 from the disabled applicant/recipient is required for each medical source. In addition, include one extra copy signed for a possible additional source. At least one release should be sent even if no medical providers are listed.

### **III. Disability Determination Section's Role**

Disability Determination Services (DDS) is under contract to the federal government to do Title II disability (Social Security) and Title XVI disability (Supplemental Security Income) claims.

The principal function of the DDS is to develop medical and vocational evidence and make decisions on disability for the Social Security Administration. Since 1974, DDS has made disability decisions for Title XIX (Medicaid) under agreement with the State. DDS does initial reconsideration and subsequent reconsiderations..

### DDS Responsibility

The DDS has responsibility to determine:

- ❖ Whether or not an individual is under a disability.
- ❖ The day the disability began (onset); i.e., the date the impairment became disabling.
- ❖ The day the disability ceases.

How disability is determined, i.e., what is done, how it is done, and why it is done, is established by the Social Security Act. Section XIX (Medicaid) refers to Section 1614 (SSI) for definition. The Act is further expanded in the Code of Federal Regulations 20 CFR 404 and 416.

Refer to Attachment D for a flow chart that describes the process for determining disability.



## Disability Interview Guide

<b>I. Fractures</b>	
<p><b>A. <u>What to Find Out</u></b></p> <ol style="list-style-type: none"> <li>1. Describe original injury*/dates.</li> <li>2. Surgery done or anticipated? Brief description.</li> <li>3. Physical/occupational therapy? Dates and places.</li> <li>4. Is fracture healing? Any known complications, e.g., infection, nerve damage, etc.?</li> <li>5. Loss of feeling? Strength? Motion? Describe.</li> <li>6. Has the doctor recommended specific activities to do or to avoid? Any date expected to return to work?</li> <li>7. Next appointment with doctor?</li> </ol>	<p><b>B. <u>What to Observe</u></b></p> <ol style="list-style-type: none"> <li>1. Is fracture still in cast?</li> <li>2. Using brace? Cane?</li> <li>3. Height and Weight.</li> <li>4. Problems walking?</li> <li>5. Note any obvious deformities.</li> </ol> <p>* Fracture may be caused by disease rather than injury, e.g., stress fracture due to osteoarthritis. Refer to arthritis guide.</p>

<b>II. Blood Disorders</b>	
<p><b>A. <u>What To Find Out</u></b></p> <ol style="list-style-type: none"> <li>1. How was condition first noticed?</li> <li>2. Any episodes of unusual bleeding? Describe/ Dates.</li> <li>3. Date and source of blood workups.</li> <li>4. Blood transfusions or blood products necessary?</li> <li>5. Current symptoms and treatment?</li> </ol>	<p><b>B. <u>What To Observe</u></b></p> <ol style="list-style-type: none"> <li>1. Height and weight.</li> <li>2. Coloring—e.g., pale, flushed, splotched, yellowish colored, or bruised. Look at skin, lips, eyes, and nail beds.</li> <li>3. Any apparent weakness or fatigue.</li> </ol>

### III. Skin Rashes and Disease

#### A. What To Find Out

1. What symptoms precluded work? (e.g., pain, itching, stiffness)
2. What causes irritation? Areas involved?
3. What can't the applicant do now that he/she could do before onset?
4. Treatment being given? Has treatment helped in the past? What medications are taken?
5. Dermatologist involved?
6. Surgery done or is it anticipated? Describe.

#### B. What To Observe

1. Any difficulty using fingers, hands, or arms? Problems walking?
2. Bruising or sores and their location?
3. Any puffiness or swelling?
4. Rashes on face? (Characteristic of systemic lupus)

### IV. Arthritis

#### A. What To Find Out

1. Describe symptoms (pain, swelling, stiffness, etc.) at onset.
2. Joints involved (or areas of back).
3. Two major joints most affected; specify left or right.
4. Activity precluded by pain and stiffness.
5. If x-rayed, record area x-rayed. Source and date.
6. Surgery done or anticipated? Describe.

#### B. What To Observe

1. Back cases - indicate approximate length of interview and degree of difficulty claimant had in sitting throughout interview.
2. How claimant walked (e.g., normal, slow, stooped, limped, etc.) Any problems using hands, arms, fingers?
3. Height and weight.
4. Any obvious deformities? Any puffiness, swelling, or redness of visible joints?



## V. Breathing Problems

### A. What To Find Out

1. When were serious breathing problems first noticed? How has the condition changed since then?
2. Coughing? Blood in sputum? Chest pain? Describe.
3. Any breathing tests (blowing in a tube)? Chest x-rays? EKGs\*? When and where?
4. How much activity causes shortness of breath? Climbing stairs? One flight or two? Making a bed? Walking? How far?
5. Describe what relieves shortness

### B. What To Observe

1. Shortness of breath?  
While sitting?  
After walking?
2. Sitting posture.  
Slumping? Sitting upright?
3. Bluish coloration around fingernails/lips?
4. Any wheezing or coughing?
5. Height and weight?

\*Electrocardiogram is the recording of the changes of the heartbeat.

## VI. Back Injuries

### A. What To Find Out

1. Describe original injury.
2. Areas of back involved?
3. Have x-rays, myelogram\*, MRI\*\*, EMG\*\*\*, or other tests been done? Source and dates.
4. Surgery done? Brief description of current or previous surgery. Sources and dates.
5. Treatment given? Brace used? Physical/occupational therapy?
6. Describe complaints of leg or arm pain. Any numbness, tingling, or weakness?
7. Any bladder/bowel problems?

### B. What To Observe

1. Any problems getting in and out of chair?
2. Describe standing posture. Any limp or other problems walking?
3. Indicate approximate length of interview and degree of difficulty claimant had in sitting throughout the interview.
4. Height and weight.

\*Myelogram is x-ray of spinal column following dye injection.

\*\*Magnetic Resonance Imaging

\*\*\*Electromyography- injection of small needles into nerves to test nerve conductivity

## VII. Deafness

### A. What To Find Out

1. Date and source of most recent hearing tests.
2. Ever used a hearing aid? Last hearing aid evaluation?
3. Both ears involved?
4. Read lips? Use sign language (If uses sign language, ask if attended school for deaf.)
5. Onset during childhood or as adult? Gradual or sudden loss? if sudden, describe.
6. Any surgery? Describe.

### B. What to Observe

1. Hearing aid(s)? Sign language? Reading lips?
2. Problems hearing during interview? Have to repeat words?
3. Claimant's speech understandable? Describe any problems.
4. Explain difficulty claimant has in communication by phone, if known.

## VIII. Kidney, Bladder Trouble

### A. What To Find Out

1. What were first symptoms? Any changes since first symptoms?
2. Any blood tests, special x-rays or other testing? Describe. Date and source.
3. Hospitalization for impairment? Any surgery (e.g., kidney removed)? When and where?
4. What medications are being taken now?
5. On dialysis? Describe frequency. Where it is done?
6. History of hypertension or diabetes?

### B. What To Observe

1. Height and weight.
2. Abnormal swelling or obvious bloating of the body?
3. Bruises or sores?

## IX. Stroke

### A. What To Find Out

1. Symptoms at onset. Where hospitalized?
2. Which extremities involved? Alleged weakness? Paralysis?
3. Problems with speech? Slurring of words?
4. Inability to understand or to communicate? Any confusion? Any depression?
5. Problem with vision? Describe.
6. Speech or physical therapy? Where? Does claimant have special exercises to do at home?

### B. What To Observe

1. Use of crutches? Walker or other supportive device? Limp or dragging of foot?
2. Weakness or difficulty using arm, hand, or fingers.
3. Difficulty with speech, slurring of words, or inability to remember words?
4. Any problem remembering dates or events? Crying or any other indication of depression?

## X. Seizures

### A. What To Find Out

1. When did seizures first occur? In childhood? After head injury? Fever?
2. Describe seizures. How long do they last? How often do they occur? When was last seizure?
3. Name several persons who have witnessed the seizures and can describe them. Ever witnessed by a physician or nurse? Names and dates.
4. What medications are being taken? Name doctor who prescribes them and monitors blood levels. How often does claimant see doctor?
5. Any skull x-rays, EEG\*, or other tests? When and where?

### B. What To Observe

1. Did claimant seem drowsy or slow to respond to questions?
2. Any problems talking? Are gums red or swollen from medication?

\*Electroencephalogram is the measuring of brain activity

## **XI. Stomach, Liver, Intestinal Problems**

### **A. What To Find Out**

1. What were first symptoms?  
How have they changed?
2. Ever hospitalized? When and where? Any surgery? Describe.
3. Any weight loss or gain because of condition? How much? Over what period?
4. Current treatment? Medication? Any diet restrictions?
5. X-rays, blood tests or other diagnostic tests? Describe. Source and dates.

### **B. What To Observe**

1. Height and weight.
2. Coloring – e.g., pale, flushed, yellow cast to white of the eye.
3. Swelling of ankles, stomach, or other obvious bloating of the body?
4. General weakness?
5. If claimant is very overweight, any problems breathing, walking, getting in and out of chair, etc?

## **XII. Heart**

### **A. What To Find Out**

1. What were first symptoms?  
How have they changed?
2. Any previous heart attacks?  
When and where hospitalized?
3. Stress test (treadmill), heart catheterization, or angiogram done? When and where?
4. Chest pain? Describe pain – what causes it and what relieves it?  
Does pain radiate to other places, e.g., arms, neck, jaw, or back?
5. Other symptoms – shortness of breath, dizziness, fainting episodes, numbness or tingling?
6. High blood pressure? How long?
7. What medications are currently prescribed?

### **B. What To Observe**

1. Shortness of breath?  
Wheezing?
2. Medications taken during interview?
3. Swelling of ankles?
4. Coloring – (e.g., blue discoloration of the lips or nail beds, flushed, pale)?

### **XIII. Neurological**

#### **A. What To Find Out**

1. How and when was condition first noticed? How has it changed since onset?
2. Describe current symptoms.
3. Is mental retardation involved?
4. Muscular weakness in arms or legs?
5. Speech impaired? Breathing affected? Seizures involved? Describe.
6. Ever hospitalized? When and where?
7. Lab tests, x-rays, spinal tap, scans, or EMG\*.
8. Physical, occupational or speech therapy involved? Sources and dates.
9. Medications taken?

#### **B. What To Observe**

1. Describe general appearance.
2. Did claimant walk to desk? Describe gait. Any problems with coordination?
3. Any problems using arms, hands, or fingers? Signing forms?
4. Any tremors, shakiness, or unusual movements? Include parts of body involved (e.g., face, whole arm, hand, fingers, etc.) in description.
5. Any speech problems?
6. Any problems breathing?

\*Electromyogram is the measuring of neuromuscular activity

### **XIV. Cancer**

#### **A. What To Find Out**

1. When was cancer diagnosed?
2. Was surgery done? Biopsies? Where hospitalized and when?
3. Location of tumor?
4. Did claimant ever have cancer before? Location of cancer? Treatment? When?
5. Describe current symptoms.
6. Describe current treatment (e.g., chemotherapy, radiation, other) and side effects of treatment.
7. Any weight loss/gain? How much? Over what period of time?

#### **B. What To Observe**

1. General appearance.
2. Height and weight.
3. Surgical scars or bandages?
4. Signs of swelling, sores, hair loss?
5. Any indications of weakness, dizziness, nausea, etc.? Describe.

## XV. Leg Pains

### A. What To Find Out

1. When was condition first noticed? How has it changed?
2. Where does leg pain occur (e.g., ankle, knee, hip, calf muscles, other)?
3. What causes leg pain to occur (e.g., standing 2 hours, walking 1 block, sitting 30 minutes, kneeling, etc.)?
4. What relieves leg pains (e.g., moving around, resting, wrapping legs with bandages, etc.)?
5. Treatment prescribed (e.g., surgery, medication, ace bandages, exercise, etc.).
6. Any surgery? Any tests for circulation e.g., Doppler studies?
7. X-rays performed? Date and source.

### B. What To Observe

1. Using aid such as crutches, walker, etc.?
2. Dragging a foot? Limping?
3. Did claimant have trouble moving leg or bending knee, hip or ankle?
4. Swelling? Location and extent of swelling.
5. Sores or discoloration? Describe.
6. Height and weight.
7. Note length of interview.

## XVI. Diabetes

### A. What To Find Out

1. When was diabetes diagnosed?  
How old was claimant?
2. How treated (e.g., diet, pills, insulin shots)? What type and how much insulin daily? Who monitors blood sugar levels?
3. Ever had severe reactions (e.g., loss of consciousness, dizziness, or nausea, etc.)? How often? Describe reaction. What causes it; relieves it?
4. Ever hospitalized?
5. Visual problems? Describe cause if known and onset. Do glasses currently correct problem? When was last visit to eye doctor?
6. Kidney problem? Describe onset, tests done, current effects of condition.
7. Heart condition? Hypertension? List tests, sources, symptoms.
8. Complaints of problems with feet? Describe symptoms, treatment.

### B. What To Observe

1. General appearance.
2. Limp or other problems standing/walking?
3. Obvious visual problems?
4. Height and weight.

## XVII. AIDS/HIV Infection

### A. What To Find Out

1. When did claimant first learn that he/she was HIV positive? Where was HIV test performed?
2. Of allegation if AIDS, what opportunistic infection (OI) caused the diagnosis to be AIDS as opposed to symptomatic HIV infection? See following list. What made diagnosis? When?
3. Any significant weight loss? How much? State normal weight prior to illness and length of time over which weight loss occurred. Has physician or clinic documented weight loss?
4. What is the absolute T4 (CD4) count? What was the date of the latest T4 test? Where performed?
5. Medications taken? AZT? For how long and how much? (500-600 mg. daily is usual dosage.) Aerosolized pentamidine? Bactrim or Septra? Any side effects of medication? Describe.
6. Oral thrush (candidiasis)? If yes, what medication is being taken for it? (Mycelex troches or nystatin are usual.) Any skin problems? Describe problems and treatment.
7. Diarrhea? Over what period of time? Frequency?
8. Problems with persistently elevated temperature? If yes, over what period of time and what is usual temperature? Has physician/clinic documented this problem?
9. Received any counseling/therapy for emotional or mental problems? Describe. List dates and sources. Any medication for this? If so, what?

### Common Opportunistic Infections

- \* Pneumocystis carinii pneumonia (PCP)
- \* Kaposi's sarcoma (KS)
- \* Toxoplasmosis
- \* Cryptococcal meningitis
- \* HIV wasting syndrome
- \* HIV dementia (encephalopathy)
- \* Cryptosporidiosis
- \* Hodgkins or non-Hodgkins lymphoma
- \* Mycobacterium avium complex (MAC)
- \* Histoplasmosis
- \* Herpes zoster (shingles)
- \* Oral hairy leukoplakia
- \* Isosporiasis
- \* Candidiasis (oral, esophageal)
- \* Cytomegalovirus (CMV), retinitis
- \* Coccidioidomycosis
- \* Herpes simplex > 1-month duration
- \* Progressive multifocal leukoencephalopathy
- \* Salmonella septicemia



## XVIII. Psychiatric

### A. What To Find Out

1. Describe current symptoms (e.g., nervousness, anxiety, depression, insomnia, weight change, etc.)
2. How long have these symptoms been present?
3. Any past hospitalizations? When and where?
4. Current treatment. Medications used.
5. What is it in past work that claimant cannot do?

Obtain the following:

6. Does claimant care for own needs (e.g., grooming, housekeeping, cooking, finances, etc.)? Describe any assistance received.
7. Describe how typical day spent. Any hobbies, recreational activities, or other interests?
8. Does claimant visit with friends, neighbors, relatives?

### B. What To Observe

1. General appearance. Neat or unkempt?  
Groomed adequately?  
Dressed appropriately?
2. Was claimant steady in walking to interview desk?  
Any unusual movements?
3. Did claimant come to interview alone? If not, did claimant rely on the other person for answers?
4. Did claimant sit still or move about in chair? Any crying or emotional outbursts?
5. Did claimant talk slowly or very fast? Too loud or too soft? Any speech impediment?
6. Were responses logical?  
Describe any unusual answers.
7. Any problems remembering dates or places?  
Any problems following directions?
8. Did claimant seem to understand what was going on in the interview?

## **XIX. Mental Retardation**

### **A. What To Find Out**

1. At what age were problems first noticed?
2. Any history of head injury, seizures, or related physical disorders?
3. Describe childhood development (if applicable), i.e., age claimant walked, talked, started school, etc.
4. Any special schooling? Dates and places. Any work training? VR or other agency?
5. Dates and sources of IQ testing.
6. Can claimant tell time? Understand directions? Use public transportation? Make change?

### **B. What To Observe**

1. Was claimant accompanied to interview? Who provided information? If another person, describe claimant's own response or attempts to respond and ability to relate during interview.
2. Can claimant sign name?
3. Appropriately groomed?
4. Slow, confused, or disoriented? Able to understand simple instructions?
5. Physical handicaps, speech problem, problem seeing?



**III. Vocational Information (include self employment)**

- A. Principal Job (job done the longest in 15 years prior to onset)
- |                         |                                 |
|-------------------------|---------------------------------|
| 1. Job Title _____      | 4. Hrs. /day _____              |
| 2. Industry _____       | 5. Days/week _____              |
| 3. Beginning date _____ | 6. Rate of pay/average earnings |
| Ending date _____       | \$_____ per _____               |
- B. Other Jobs – List of jobs done in last 15 years prior to alleged onset date. Give approximate dates of employment ( use additional sheet if necessary)
- \_\_\_\_\_
- \_\_\_\_\_
- 

- C. Education/Highest Grade Completed \_\_\_\_\_
- High School Graduate? \_\_\_\_\_
- Name and address of school if known \_\_\_\_\_
- Additional education \_\_\_\_\_ Type \_\_\_\_\_ Is claimant currently attending school? \_\_\_\_\_
- Name of school and address if known \_\_\_\_\_
- Can claimant read and write? \_\_\_\_\_

**IV. List all Medical Sources (physicians, hospitals, nursing homes, clinics, mental health centers,) including names and dates seen in the last twelve months. Give hospital or clinic number, which is on hospital or clinic card or hospital bills. (Twelve months prior to and including application month, plus any future medical appointments)**

Medical Source Name, Address, Ph. #	Condition Treated EKG, X-rays	Dates Seen at Dr.'s office, clinic, hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Is claimant still being treated? Yes \_\_\_\_ No \_\_\_\_

- V. **VR Referral** \_\_\_\_ **Yes** \_\_\_\_ **No** **Date last seen** \_\_\_\_\_
- VR Office** \_\_\_\_\_
- Counselor's Name** \_\_\_\_\_ **Phone #** \_\_\_\_\_

**VI. If a mental impairment is alleged, please give name, address and phone number of someone who can act as a responsible party.**

\_\_\_\_\_

Signature \_\_\_\_\_

Title \_\_\_\_\_

Telephone # \_\_\_\_\_

STATE OF NORTH CAROLINA  
DEPARTMENT OF HEALTH and HUMAN SERVICES  
SOCIAL HISTORY SUMMARY FOR THE DISABLED

\_\_\_\_\_ County Department of Social Service Date \_\_\_\_\_

CLAIMANT \_\_\_\_\_ SSN \_\_\_\_\_

County Case # \_\_\_\_\_ District # \_\_\_\_\_

Telephone # or a number you can be reached (\_\_\_\_)(Give a friend or relative's # if client has no phone)

Person Providing Information and Telephone # (if different from claimant)  
\_\_\_\_\_

Nature of Disability (based on claimant's description or statement)

**I. Onset of Impairment**

- A. Date of illness or injury began (**Date of injury or date illness first bothered claimant**)
- B. Date claimant stopped work (**Whether due to impairment or not, if no longer working**)
- C. Date the illness or injury became disabling (**May be same as date in A and /or B**)
- D. If still working: \_

Name of Employer (**Complete if still working**)

Supervisor's name and telephone # \_\_\_\_\_

Hours worked \_\_\_\_\_

Gross earnings \_\_\_\_\_ weekly \_\_\_\_\_ monthly \_\_\_\_\_

**II. Claimant's Description of Impairment**

- A. Indicate how the claimant describes the symptoms of the disability and how they affect his ability to work.  
(**Describe symptoms and effect in detail: Type, Frequency, Severity, Dr.'s restrictions**)
  
- B. Describe claimant's daily activities and explain how the impairments affect him such as seeing, hearing, speaking, reading, walking, writing, standing, breathing, sitting, using hands, arms, and other joints.  
(**Describe how his impairments limit what he can do**)
  
- C. Worker's Observation of Difficulties  
(**Note any observation of any physical or mental difficulties, even if they do not relate to the alleged impairment.**)

**III. Vocational Information (include self employment)**

- A. Principal Job (job done the longest in 15 years prior to onset)
- |   |                                 |
|---|---------------------------------|
| 1. Job Title (Name given by client)             | 4. Hrs. /day (#hrs. per day)    |
| 2. Industry (Type of industry not company name) | 5. Days/week (#days per week)   |
| 3. Beginning date (Year entered job)            | 6. Rate of pay/average earnings |
| Ending date (Year left job)                     | \$_____per (Wk/Month)           |
- B. Other Jobs – List of jobs done in last 15 years prior to alleged onset date. Give approximate dates of employment ( use additional sheet if necessary) (List jobs by title, industry, dates worked. Identify self-employment and nature of business ) (Prompting may be necessary to obtain complete listing.)

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- C. Education/Highest Grade Completed (highest grade)
- High School Graduate? (Yes or No)
- Name and address of school if known \_\_\_\_\_
- Additional education \_\_\_\_\_ Type (Be specific) Is claimant currently attending school? (Yes or No)
- Name of school and address if known \_\_\_\_\_
- Can claimant read and write? (Yes or No)

**IV. List all Medical Sources (physicians, hospitals, nursing homes, clinics, mental health centers,) including names and dates seen in the last twelve months. Give hospital or clinic number, which is on hospital or clinic card or hospital bills. (Twelve months prior to and including application month, plus any future medical appointments)**

Medical Source Name, Address, Ph. # (Full name of treating source)	Condition Treated EKG, X-rays (What condition and what tests)	Dates Seen at Dr.'s office, clinic, hospital (Approximate dates seen)
Full address if known. If unknown request from A/R. Must have full address for out of state providers. For NC providers, minimum requirement is full name and city)		* Ask client about all medical sources for past years; indicate at end of list that A/R has no other treating sources.

Is claimant still being treated? Yes \_\_\_\_ No \_\_\_\_

- V. VR Referral** \_\_\_\_ Yes \_\_\_\_ No **Date last seen** (Approximate date) \_\_\_\_\_
- VR Office** (Name of City)
- Counselor's Name** (If known) **Phone #** (If known)

**VI. If a mental impairment is alleged, please give name, address and phone number of someone who can act as a responsible party. (Required to get name of responsible party if mental impairment. Also, very helpful to get name of responsible party if physical impairment)**

Signature \_\_\_\_\_

Title \_\_\_\_\_

Telephone # \_\_\_\_\_



**State of North Carolina  
Department of Human Resources  
Social History Summary for the Disabled and Selected AFDC Cases**

\_\_\_\_\_ County Department of Social Services      Date \_\_\_\_\_

Claimant \_\_\_\_\_ SSN \_\_\_\_\_

Case # \_\_\_\_\_ District # \_\_\_\_\_ Telephone # \_\_\_\_\_

Person Providing Information (If different from above) \_\_\_\_\_

**Identifying information is important. The DDS examiner often needs to contact the applicant, so if he states he has no phone, a "can be reached" number is very helpful.**

Nature of Disability (based on claimant's description/statement)



I. Onset of Impairment

- A. Date illness or injury began \_\_\_\_\_
- B. Date claimant stopped work \_\_\_\_\_
- C. Allegation of onset \_\_\_\_\_
- D. If still working:

Name of Employer \_\_\_\_\_  
Supervisor's name and Telephone # \_\_\_\_\_  
Hours worked \_\_\_\_\_  
Gross earnings \_\_\_\_\_ Weekly \_\_\_\_\_ Monthly \_\_\_\_\_

I. Onset of "impairment". "Impairment" means the disease or injury itself. It may or may not be severe enough to be disabling.

Important information about the impairment:

- A. When applicant was injured or first became ill. In other words, when did the symptoms first appear?
- B. When applicant stopped work. If he has never been employed put "never worked". If he is still actually working put "still working" and complete D. in Section I.

If applicant did work but no longer does, enter the approximate date he stopped. This information will help to establish the onset dates of disability.

- C. The date that the impairment became disabling. This may be the same as the dates in A or B, but could be a later date. The onset might be traumatic (due to bodily injury by external forces; non traumatic (of an acute condition such as heart attack); or progressive (of gradual illness such as arthritis, mental illness, etc.)
- D. If the applicant is still working, DDS will need to verify the amount of wages to determine whether the claimant is engaging in SGA (refer to glossary).

Note: Do not complete D if claimant is not actually working (i.e. if still employed but is on leave).

II. Claimant's Description of Impairment

- A. Indicate how the claimant describes the symptoms of the disability and how they affect his ability to work.
- B. Describe claimant's daily activities and explain how the impairments affect him such as seeing, hearing, speaking, reading, walking, writing, standing, breathing, sitting, using hands and arms and other joints.
- C. Worker's Observation of Difficulties

## II. Claimant's Description of Impairment

- A. In applicant's own words, describe what the symptoms are. Also ask questions such as:
  - ❖ What, if anything, brings on the symptoms?
  - ❖ What relieves them? For example, if one symptom is leg pain, does sitting relieve the pain? Does any medication relieve the symptoms?
  - ❖ What is applicant unable to do as a result of the symptoms? How long can he stand? How far can he walk?
- B. In describing the applicant's daily activities it may be necessary to ask specific questions:
  - ❖ Can he see well enough to read the newspaper? Does he watch television? If not, is it because he cannot see well enough?
  - ❖ Can he go to the grocery store? If so, does he need help to lift the groceries out of the car?
  - ❖ If he says he does housework, ask if there are any tasks he cannot do. Can he change bed linens? Can he vacuum? Sweep? Can he stand long enough to do dishes?

Try to find out what has changed in his daily activities since the alleged disability began.

If the impairment appears to be mental, it is very important to note any unusual behavior. For example, does he believe the program he saw last night was about him? Does his mother have to remind him to take a bath? Does he claim that he prepares all his own meals but admits that all of his meals consist of cold cereal?

- C. The IMC's observation of the applicant is very important. Anything that is noticeable is significant enough to write down. Observations by the IMC can and should go beyond the alleged impairment. For example, he is applying based on high blood pressure but IMC observes he is slow in understanding. Or, he is applying based on chronic bronchitis but IMC observes he only has one arm. Or, he is applying based on "nerves" but IMC observes he must hold the papers very close to read them. If the IMC observed no difficulties, it is important to say so.

## III. Vocational Information

- A. Principal Job (Job done the longest in 15 years prior to alleged onset)
- |                         |                                |
|-------------------------|--------------------------------|
| 1. Job title _____      | 4. Hrs/day _____               |
| 2. Industry _____       | 5. Days/week _____             |
| 3. Beginning date _____ | 6. Rate of pay/average earning |
| Ending date _____       | \$ _____ per _____             |
- B. Other Jobs: list of jobs done in last 15 years prior to alleged onset date. Give approximate dates of employment (use attached sheet if necessary).
- C. Education/Highest Grade Completed \_\_\_\_\_  
 High School Graduate? \_\_\_\_\_ GED \_\_\_\_\_  
 Additional education (college, vocational, technical)? \_\_\_\_\_  
 Can claimant read and write? \_\_\_\_\_

**III. Vocational**

The significance of this information relates to DDS's decision as to whether the impairment is actually severe enough to affect his ability to work.

Education level also impacts this decision. It is important to answer all questions in this area. The applicant's ability to read and write might determine his disability status. It cannot be assumed that because he reached the 8<sup>th</sup> grade, he is able to read and write.

- IV. List all Medical Sources (physicians, hospitals, nursing homes, clinics, mental health centers, and health departments) including names and dates seen in the last twelve months. Give hospital or clinic number, which is on clinic cards or hospital bills.

Is claimant still being treated? Yes \_\_\_\_ No \_\_\_\_

- IV. Social Security regulations require DDS to contact all medical sources that examined or treated applicant in the last 12 months. Therefore, list full names and addresses of treating sources (doctor, hospital, health department, physical therapist, mental health center, emergency room, etc.) It is helpful to spell out the full name of the location rather than abbreviate.

Medical Source Name, Address, Phone#	Condition Treated and Special Studies EKG, X-rays	Dates seen at Dr.'s office, clinic, hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

It is important to know if the claimant is still being treated for any medical condition.

- V. VR Referral \_\_\_\_ Yes \_\_\_\_ No      Date last seen \_\_\_\_\_  
VR Office \_\_\_\_\_  
Counselor's Name \_\_\_\_\_ Phone # \_\_\_\_\_  
\_\_\_\_\_

V. VR Referral

This information is needed if the applicant has already been referred to VR. If he has, DDS must contact the VR office and request information from the VR record.

- VI. If mental impairment is alleged, please give name, address and phone number of someone who can act as a responsible party.

- VI. It is extremely helpful to list the name of a responsible party for all cases. The DDS examiner may use the person to get more information about the applicant's activities of daily living. The third party might be useful in reminding or helping applicant get to a consultative examination. He can assist in other ways such as read letters from DDS to the applicant if illiterate.

### DISABILITY CASE PROCESSING FLOW CHART

