

INITIAL MEDICAL EXAMINATION

MEDICAL RE-EXAMINATION

THIS SECTION TO BE COMPLETED BY COUNTY – Please print

NAME (Last, First, Middle)		SOCIAL SECURITY NO.		DATE OF BIRTH		SEX M F	
ADDRESS (If in N.F., give name & Address of N.F.)			COUNTY	TECH #	CATEGORY	CASE NUMBER	
CITY, STATE, ZIP CODE					DATE OF APPLICATION MO. DAY YR.		
NOW UNDER CARE OF PHYSICIAN? <input type="checkbox"/> YES or <input type="checkbox"/> NO		DATE OF LAST VISIT	NAME & ADDRESS OF PHYSICIAN				
USUAL OCCUPATION AND DESCRIPTION OF LAST JOB							
APPLICANT'S STATEMENT OF DISABILITY OR INCAPACITY							
PRINTED NAME OF COUNTY REPRESENTATIVE				TELEPHONE NUMBER		DATE	

PURPOSE OF THIS FORM: This form is used by the State and County Departments of Human Services in determining medical eligibility for the State Aid to the Needy Disabled (AND) program. To be eligible for this program, an individual must have a total disability that has lasted or is expected to last six (6) months or more, and precludes him/her from working. The exam may be completed by an examining physician (or psychiatrist), physician assistant certified in Colorado, by an advanced practice nurse, or by a registered nurse licensed in this state who is functioning within the scope of such nurse's license and training. This form must be signed by the supervising physician (or psychiatrist), or the physician or nurse who actually conducted the examination.

ALL SECTIONS FOLLOWING ARE TO BE COMPLETED BY MEDICAL EXAMINER – Please print

PRIMARY DIAGNOSIS IS ALCOHOLISM OR CONTROLLED SUBSTANCE ADDICTION

Checking this box means there is no other physical or mental disability(ies) that precludes this person from working other than his/her alcohol or controlled substance addiction. If this box is checked, the individual will be offered treatment and will be expected to work once treatment is complete.

CERTIFICATION OF AUTHORIZED MEDICAL PERSONNEL AS DEFINED ABOVE (Please check only one box)

The medical determination of disability cannot be based solely on the client's statement; it must include a medical evaluation.

1. I find this individual has been or will be disabled to the extent they are unable to work at **any** job for a total period of six (6) or more months due to a physical or mental impairment that is disabling.
OR
2. I find this individual is **not totally** disabled but does have a physical or mental impairment that **substantially** precludes this person from engaging in his/her **usual** occupation. This condition has been or will be for a period of six (6) months or longer.
OR
3. I find this individual does **not** have a physical or mental impairment that is disabling.

DATE OF EXAMINATION: _____ DATE OF ONSET OF DISABILITY: _____

Please be sure to sign where indicated at the bottom of this page.

If this is a Medical Re-Examination, please complete this box. If not, skip to "DIAGNOSIS," below.

- ♦ Have you received and reviewed the last MED-9 Medical Examination form? YES NO
 - ♦ In comparison with the last examination, has there been material improvement in physical or mental condition? YES NO
- If YES, please describe:

DIAGNOSIS (pertaining to disabilities):

PROGNOSIS – EXPECTED LENGTH OF DISABILITY:

- Less than 12 months:** 1-2 months _____ 3-5 months _____ 6-8 months _____ 9-11 months _____
- 12 months or longer**

What symptoms or problems need to be alleviated to allow this person to be employable? (NOTE: This section is helpful to establish clearer criteria for recovery and give a point of comparison to the last examination.)

RELEVANT CLINICAL HISTORY AND MENTAL STATUS:

Please refer to "Purpose Of This Form" on front page as to who can legally sign this form.

SIGNATURE OF SUPERVISING PHYSICIAN, OR THE PHYSICIAN OR NURSE WHO ACTUALLY CONDUCTED THE EXAMINATION	DEGREE	STATE	LICENSE #	DATE

PRINTED NAME, ADDRESS, AND PHONE NUMBER. (This information is needed to insure the accuracy of this report.)
