Medical Review Team Packet to Determine Disability

The Medical Review Team (MRT) Packet is for disabled applicants who are under age 65 and do not receive Social Security Disability or SSI.

Family Support Division (FSD) must have a completed packet to determine your disability. Incomplete packets may result in a delay, or your application may be rejected. Fill out each form completely.

1. **Disability History**: Complete pages 3-4 to describe your disability in detail so we know what records or evaluations are needed.
2. **Work History:** Complete pages 5-6 to show your work history. List where you have worked over the last 10 years, so we know if you have been substantially and gainfully employed.
3. **Provider History:** Complete pages 7-8 listing all of the doctors, hospitals, and other providers who have treated your disability in the last 12 months so we can get your records.
4. **Authorization for Disclosure of Confidential Information:** Sign and date at the X in the middle of page 10 (directly after number 6) to give FSD permission to get your medical records from your medical providers.
   Note: All medical providers require a signature on page 10 (directly after number 6).
   - Some providers may also require a witness signature; if you have a witness available, please have them sign.
   - Even if you do not have substance abuse treatment information, many providers require a signature in the middle of page 10 to disclose substance abuse treatment information. Sign and date at the X in this section.
   - Medical providers CANNOT release any information to FSD if you sign the Notice of Revocation (at the bottom of page 10).

For faster service, provide medical records
FSD must use medical records to make your disability determination. It will expedite processes if you can provide any medical records from the last 12 months. You may have access to your medical records through your provider's patient portal.

FSD will request the medical records from providers you list on your Provider History. If your provider does not respond to a request for records timely, that may cause a delay in your disability determination. FSD can only pay for records that they have requested.

If you have not seen any medical providers, or FSD needs more information, FSD will schedule an appointment for you. FSD will pay for this appointment with a doctor, at a location, and at a time scheduled by FSD. It will be an evaluation only (no treatment or referrals). Failure to go to your appointment may result in your application being rejected.

Need help with your application? Call us at 855-373-4636. If you need help in a language other than English, tell the customer service representative the language you need. TTY users can call: 800-735-2966.

Ways to return this form and medical records:

	Upload Online:
	Mydssupload.mo.gov
	Mail:
	Family Support Division PO Box 2700 Jefferson City, MO 65102
	In Person:
	Find an office: https://dss.mo.gov/dss_map/
	Fax:
	573-526-9400

If you are a Veteran in the state of Missouri and are interested in learning more about benefits and resources available to you and your dependents, visit: https://mvc.dps.mo.gov/MoVeteransInformation/Survey/DSS

Or scan the QR code:

MISSOURI DEPARTMENT OF SOCIAL SERVICES
FAMILY SUPPORT DIVISION

DISABILITY HISTORY

SAVE PRINT RESET

INDIVIDUAL NAME (FIRST, MIDDLE, LAST)	INDIVIDUAL DCN	DATE OF BIRTH

1. Personal Information: Age _____ Sex _____ Height _____ Weight _____
2. Highest Education Level Completed: ☐Some high school ☐High school diploma ☐GED/HiSET ☐Some college ☐College degree ☐Advanced degree
3. What is your main disabling diagnosis or problem?
4. What physical symptoms and problems do you have?
5. What mental health symptoms and problems do you have?
6. List every medication you take, why you take it, how often it is taken, and who prescribed it or if it is over the counter. If additional space is needed, use the Additional Information space on the next page or attach additional pages.

Medication Name	Reason for medication	Dose and frequency	Prescribing Doctor or over the counter
Ex: Omeprazole	Ulcers	Once a day	Dr. John Smith
Ex: Ibuprofen	Back pain	400 mg every 4 hours	Over the counter

7. When did your medical issues first prevent you from working?

8. What are the limitations of your daily activities due to your disability? Please list activities you are unable to perform.

8a. Do you require a walker, cane, or other assistive device to walk or stand? ☐ Yes ☐ No

8b. Are you in need of caretaking? ☐ Yes ☐ No

8c. If yes, who provides? ☐ Family or friend ☐ Nurse ☐ Skilled Nursing Facility or other care facility

9. Have you applied for Social Security? ☐ Yes ☐ No

9a. Were you examined by a doctor for that application? ☐ Yes ☐ No

9b. What is the status of your application? ☐ Pending Decision ☐ Approved ☐ Rejected ☐ Appealed

Additional Information and Comments

MISSOURI DEPARTMENT OF SOCIAL SERVICES
FAMILY SUPPORT DIVISION

WORK HISTORY - PAST 10 YEARS

INDIVIDUAL NAME (FIRST, MIDDLE, LAST)	INDIVIDUAL DCN	DATE OF BIRTH

Instructions: Please list all employers within the last ten (10) years, starting with the most recent. If you had more employers, please continue on a separate sheet and attach to this form.

EMPLOYER		TELEPHONE NUMBER
EMPLOYER'S ADDRESS (STREET, CITY, STATE, ZIP CODE)		
DATES OF EMPLOYMENT: FROM (MONTH/YEAR)	TO (MONTH/YEAR)	GROSS EARNED MONTHLY INCOME $
JOB DESCRIPTION/DUTIES		
REASON FOR LEAVING	WAS THIS THROUGH A SHELTERED WORKSHOP? ☐ YES ☐ NO	

EMPLOYER		TELEPHONE NUMBER
EMPLOYER'S COMPLETE ADDRESS (STREET, CITY, STATE, ZIP CODE)		
DATES OF EMPLOYMENT: FROM (MONTH/YEAR)	TO (MONTH/YEAR)	GROSS EARNED MONTHLY INCOME $
JOB DESCRIPTION/DUTIES		
REASON FOR LEAVING	WAS THIS THROUGH A SHELTERED WORKSHOP? ☐ YES ☐ NO	

EMPLOYER		TELEPHONE NUMBER
EMPLOYER'S COMPLETE ADDRESS (STREET, CITY, STATE, ZIP CODE)		
DATES OF EMPLOYMENT: FROM (MONTH/YEAR)	TO (MONTH/YEAR)	GROSS EARNED MONTHLY INCOME $
JOB DESCRIPTION/DUTIES		
REASON FOR LEAVING	WAS THIS THROUGH A SHELTERED WORKSHOP? ☐ YES ☐ NO	

EMPLOYER		TELEPHONE NUMBER
EMPLOYER'S COMPLETE ADDRESS (STREET, CITY, STATE, ZIP CODE)		
DATES OF EMPLOYMENT: FROM (MONTH/YEAR)	TO (MONTH/YEAR)	GROSS EARNED MONTHLY INCOME $
JOB DESCRIPTION/DUTIES		
REASON FOR LEAVING	WAS THIS THROUGH A SHELTERED WORKSHOP? ☐ YES ☐ NO	

INDIVIDUAL NAME (FIRST, MIDDLE, LAST)	INDIVIDUAL DCN	DATE OF BIRTH

EMPLOYER		TELEPHONE NUMBER
EMPLOYER'S COMPLETE ADDRESS (STREET, CITY, STATE, ZIP CODE)		
DATES OF EMPLOYMENT: FROM (MONTH/YEAR)	TO (MONTH/YEAR)	GROSS EARNED MONTHLY INCOME $
JOB DESCRIPTION/DUTIES		
REASON FOR LEAVING	WAS THIS THROUGH A SHELTERED WORKSHOP? ☐YES ☐NO	

EMPLOYER		TELEPHONE NUMBER
EMPLOYER'S COMPLETE ADDRESS (STREET, CITY, STATE, ZIP CODE)		
DATES OF EMPLOYMENT: FROM (MONTH/YEAR)	TO (MONTH/YEAR)	GROSS EARNED MONTHLY INCOME $
JOB DESCRIPTION/DUTIES		
REASON FOR LEAVING	WAS THIS THROUGH A SHELTERED WORKSHOP? ☐YES ☐NO	

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EMPLOYER'S COMPLETE ADDRESS (STREET, CITY, STATE, ZIP CODE)		
DATES OF EMPLOYMENT: FROM (MONTH/YEAR)	TO (MONTH/YEAR)	GROSS EARNED MONTHLY INCOME $
JOB DESCRIPTION/DUTIES		
REASON FOR LEAVING	WAS THIS THROUGH A SHELTERED WORKSHOP? ☐YES ☐NO	

EMPLOYER		TELEPHONE NUMBER
EMPLOYER'S COMPLETE ADDRESS (STREET, CITY, STATE, ZIP CODE)		
DATES OF EMPLOYMENT: FROM (MONTH/YEAR)	TO (MONTH/YEAR)	GROSS EARNED MONTHLY INCOME $
JOB DESCRIPTION/DUTIES		
REASON FOR LEAVING	WAS THIS THROUGH A SHELTERED WORKSHOP? ☐YES ☐NO	

EMPLOYER		TELEPHONE NUMBER
EMPLOYER'S COMPLETE ADDRESS (STREET, CITY, STATE, ZIP CODE)		
DATES OF EMPLOYMENT: FROM (MONTH/YEAR)	TO (MONTH/YEAR)	GROSS EARNED MONTHLY INCOME $
JOB DESCRIPTION/DUTIES		
REASON FOR LEAVING	WAS THIS THROUGH A SHELTERED WORKSHOP? ☐YES ☐NO	

MISSOURI DEPARTMENT OF SOCIAL SERVICES
FAMILY SUPPORT DIVISION

PROVIDER HISTORY

INDIVIDUAL NAME (FIRST, MIDDLE, LAST)	INDIVIDUAL DCN	DATE OF BIRTH

Instructions: List all hospitals, medical facilities, and physicians that have provided care or services to you within the last twelve (12 months). You must provide complete names, phone numbers, and addresses to avoid processing delays. If needed, use a separate sheet and attach to this form.

If you have not had any medical care in the last 12 months, check here: ☐ **NONE**

DO YOU HAVE A PRIMARY CARE PHYSICIAN?

☐ **YES** ☐ **NO** **If yes, provide information for your primary care physician first. If no, begin listing providers you have seen.**

FACILITY AND DOCTOR NAME(S)		TELEPHONE NUMBER
COMPLETE ADDRESS (STREET, CITY, STATE, ZIP CODE)		
REASON(S) SEEN		DIAGNOSIS
LAST DATE SEEN	HOSPITALIZATION ☐ YES ☐ NO	DURATION
UPCOMING APPOINTMENTS/DATES		

FACILITY AND DOCTOR NAME(S)		TELEPHONE NUMBER
COMPLETE ADDRESS (STREET, CITY, STATE, ZIP CODE)		
REASON(S) SEEN		DIAGNOSIS
LAST DATE SEEN	HOSPITALIZATION ☐ YES ☐ NO	DURATION
UPCOMING APPOINTMENTS/DATES		

FACILITY AND DOCTOR NAME(S)		TELEPHONE NUMBER
COMPLETE ADDRESS (STREET, CITY, STATE, ZIP CODE)		
REASON(S) SEEN		DIAGNOSIS
LAST DATE SEEN	HOSPITALIZATION ☐ YES ☐ NO	DURATION
UPCOMING APPOINTMENTS/DATES		

FACILITY AND DOCTOR NAME(S)		TELEPHONE NUMBER
COMPLETE ADDRESS (STREET, CITY, STATE, ZIP CODE)		
REASON(S) SEEN		DIAGNOSIS
LAST DATE SEEN	HOSPITALIZATION ☐ YES ☐ NO	DURATION
UPCOMING APPOINTMENTS/DATES		

INDIVIDUAL NAME (FIRST, MIDDLE, LAST)	INDIVIDUAL DCN	DATE OF BIRTH

FACILITY AND DOCTOR NAME(S)		TELEPHONE NUMBER
COMPLETE ADDRESS (STREET, CITY, STATE, ZIP CODE)		
REASON(S) SEEN		DIAGNOSIS
LAST DATE SEEN	HOSPITALIZATION ☐ YES ☐ NO	DURATION
UPCOMING APPOINTMENTS/DATES		

FACILITY AND DOCTOR NAME(S)		TELEPHONE NUMBER
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REASON(S) SEEN		DIAGNOSIS
LAST DATE SEEN	HOSPITALIZATION ☐ YES ☐ NO	DURATION
UPCOMING APPOINTMENTS/DATES		

FACILITY AND DOCTOR NAME(S)		TELEPHONE NUMBER
COMPLETE ADDRESS (STREET, CITY, STATE, ZIP CODE)		
REASON(S) SEEN		DIAGNOSIS
LAST DATE SEEN	HOSPITALIZATION ☐ YES ☐ NO	DURATION
UPCOMING APPOINTMENTS/DATES		

FACILITY AND DOCTOR NAME(S)		TELEPHONE NUMBER
COMPLETE ADDRESS (STREET, CITY, STATE, ZIP CODE)		
REASON(S) SEEN		DIAGNOSIS
LAST DATE SEEN	HOSPITALIZATION ☐ YES ☐ NO	DURATION
UPCOMING APPOINTMENTS/DATES		

STATE OF MISSOURI

AUTHORIZATION FOR DISCLOSURE OF CONSUMER MEDICAL/HEALTH INFORMATION

I, _____ authorize and request
(NAME OF CONSUMER, PARENT, GUARDIAN/LEGAL REPRESENTATIVE)

Check all that apply:

☐ Department of Mental Health (DMH)
☐ Department of Health and Senior Services (DHSS)
☐ Department of Social Services (DSS)
☐ Department of Elementary and Secondary Education (DESE)
☐ any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility or other health care provider that has provided payment, treatment or services to me or on my behalf.
☐ Other _____
(NAME OF FACILITY, AGENCY, MENTAL HEALTH CENTER, PERSON)

to **disclose/release** the below specified information of:

NAME	DCN	DATE OF BIRTH	SOCIAL SECURITY NUMBER

WHO RECEIVED SERVICES ON (DATES)

To: **(check all that apply)**

☐ Department of Mental Health (DMH)
☐ Department of Health and Senior Services (DHSS)
☐ Department of Social Services (DSS)
☐ Department of Elementary and Secondary Education (DESE)
☐ Other _____
(NAME OF FACILITY, AGENCY, MENTAL HEALTH CENTER, PERSON)

_____
(ADDRESS, CITY, STATE, ZIP)

THE PURPOSE OF THIS DISCLOSURE IS (CHECK ALL THAT APPLY)

☐ Eligibility Determination
☐ Assessment
☐ Aftercare
☐ Placement
☐ Transfer/Treatment
☐ Treatment Planning
☐ Continuity of Services/Care
☐ Conditional/Unconditional Release Hearing
☐ At Consumer's Request
☐ To share or refer my information to other Missouri state agencies (such as DMH, DHSS, DSS, DESE, DOC, MVC, etc.) to obtain services consistent with the _____ program (please complete the name of the program in which you want to participate)
☐ Other (specify) _____
☐ Do a general medical evaluation, psychological evaluation, orthopedic evaluation, or _____ evaluation, and, if applicable, complete the enclosed IM-60A. The examination may include test(s) which are indicated by the patient's complaints and are necessary before you can reach a decision on his/her employability. The examination is scheduled for _____ at _____. The Family Support Division will honor a physician's usual and customary charges, up to but not exceeding our professional reimbursement schedule. If, in your opinion, the patient must be hospitalized in order for you to complete this medical report, Prior Written Authorization by the State Medical Review Team must be given before payment will be made by the Family Support Division.

THE SPECIFIC INFORMATION TO BE DISCLOSED IS (CHECK ALL THAT APPLY)

☐ Discharge Summary
☐ Progress Notes
☐ Treatment Plan and/or Review
☐ Social Service Assessment
☐ Educational testing, IEP, transcript, and/or grading reports protected by 34 CFR Part 99
☐ Medical/Psychiatric Assessment(s), and, if applicable, complete the certification section of the enclosed IM-60A.
☐ Psychometric testing, including intelligence quotient (IQ) results, neurological testing, or other developmental test results.
☐ Other _____
☐ Hospital's Pertinent data: History and Physical, Discharge Summary, Consultative Exams, Lab Reports, Radiology Reports including MRI and CT Scans, Cardiology Records, Operative Reports, Pathology Reports, and Emergency Room Records

1. **READ CAREFULLY:** I understand that my medical/health information records are confidential. I understand that by signing this authorization, I am allowing the release of any and all of my medical/health information whether past, present or created in the future up to the expiration or revocation date of this authorization, unless otherwise indicated. The protected health information (PHI) in my medical record includes mental/behavioral health information. In addition, it may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), and/or other communicable diseases or environmental diseases and conditions.
2. This authorization includes both information presently compiled and information to be compiled during the course of treatment at the above-named facility or agency paying for services, during the specified time frame.
3. Unless otherwise indicated, this authorization become effective on the date of signature below and will expire one year from that date.
4. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so **IN WRITING** and present my written revocation to the health information management department (medical records) or client information center at this facility. I further understand that actions already taken based on this authorization, prior to revocation, will **NOT** be affected.
5. I understand that I have the right to receive a copy of this authorization. **A photographic copy of this authorization is as valid as the original.**
6. I understand that authorizing the disclosure of this medical/health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may request to inspect or request a copy of information to be used or disclosed, as provided in 45 CFR Section 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my medical/health information, I can contact the health information management director (medical records director) or client information center, or designee, or the Privacy Officer for this covered entity.

MY SIGNATURE BELOW ACKNOWLEDGES THAT I HAVE READ, UNDERSTAND, AND AUTHORIZE THE RELEASE OF MY PHI.

SIGNATURE OF CONSUMER X	DATE X
WITNESS	DATE
SIGNATURE OF PARENT/LEGAL GUARDIAN/REPRESENTATIVE	

(Please include a Description of Authority to Act on Consumer's Behalf and attach a copy of the Document Granting Authority, where applicable)

AUTHORIZATION TO DISCLOSE SUBSTANCE ABUSE TREATMENT INFORMATION

Alcohol and drug abuse treatment records are specifically protected by federal regulations (42 CFR Part 2) and by signing in the block below, I am allowing the release of any alcohol and/or drug information records (if any) that I may have to the agency or person specified on this form. Prohibition of Redisclosure: Federal regulations (42 CFR Part 2) prohibit the recipient of substance abuse treatment records from making further disclosure of those records without the specific written authorization of the person to whom those records pertain, or as otherwise specified by such regulation. A general authorization for disclosure of medical or other information is NOT sufficient for this purpose. Sign below **if you wish to authorize** the release of **alcohol and drug abuse information.**

SIGNATURE OF CONSUMER X	DATE X

NOTICE OF REVOCATION

DATE

I, _____ , (Consumer) hereby revoke my authorization of this disclosure of information to the agency/person listed above. This revocation effectively makes null and void any permission for disclosure of information expressly given by the above authorization. I understand that any actions based on this authorization, prior to revocation, will not be affected.

SIGNATURE OF CONSUMER	DATE
WITNESS	DATE
SIGNATURE OF PARENT/LEGAL GUARDIAN/REPRESENTATIVE	DATE

If you choose to revoke your authorization, please provide a copy of the completed revocation to the health information management director (medical records director), or the client information center, or to the Privacy Officer of this facility.