Missouri Department of Social Services
Family Support Division

Medical Review Team Packet to Determine Disability

Directions:

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

Filling out these 4 forms may speed up the application process. They do not have to be submitted with the application.

1. **Disability History:** Describe your disability in detail so we know what records or tests are needed (pages 2-3).

2. **Work History:** List where you have worked over the last 10 years so we know if you have been substantially and gainfully employed (pages 4-5).

3. **Provider History:** List the doctors, hospitals, and other providers who have treated your disability in the last 5 years so we can get your records faster (pages 6-7).

4. **Authorization to Release Health Information:** Allow us permission to get your medical records from your doctor and other providers (pages 8-9).

Need help with your application? Call us at 1-855-373-4636. If you need help in a language other than English, tell the customer service representative the language you need. TTY users can call: 1-800-735-2966.

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MISSOURI DEPARTMENT OF SOCIAL SERVICES
FAMILY SUPPORT DIVISION

DISABILITY HISTORY

NAME	DCN	DATE

Pertinent Information and Observations of FSD Staff:

1. Personal Information: Age _____ Sex _____ Height _____ Weight _____
2. Highest Grade Completed: _____ GED ☐ Yes ☐ No

3a. What physical symptoms/problems do you have?

3b. What mental health symptoms/problems do you have?

Do you have crying spells or depression because of your disability? ☐ Yes ☐ No How often? _____

3c. Are your mental health symptoms due to your current circumstances (i.e. family, job, health)? ☐ Yes ☐ No

4. When did these symptoms/problems begin? _____
5. When did these symptoms first prevent you from working?

6. What are the limitations of your daily activities from this disability? Please list those you are **unable** to perform:

   Able to perform?

   Are you in need of caretaking? ☐ Yes ☐ No

   If yes, who provides? (Check one) ☐ Nurse ☐ Relative ☐ Neighbor ☐ Friend ☐ Other:

7. Did you see a doctor or seek medical treatment for your symptoms? ☐ Yes ☐ No

   Physician _____ How often? _____

   Treatment received _____

   When? _____

   Physician _____ How often? _____

   Treatment received _____

   When? _____

8. Have you been given a specific diagnosis for your problem? ☐ Yes ☐ No What is the diagnosis? _____

   _____

9. Have you gone to Vocational Rehabilitation? ☐ Yes ☐ No (If yes, obtain VR reports and any medical examinations required by VR) What is the status of your Vocational Rehabilitation referral?

   _____

10. Have you applied for (check if applicable)? ☐ Social Security ☐ SSI ☐ VA

Were you examined by a doctor for this application? ☐ Yes ☐ No (If yes, obtain medical reports from SSA)

What is the status of your application? _____

11. Did your problem require physical therapy? ☐ Yes ☐ No (Obtain medical information or reports)

If yes, where? When? _____

Describe therapy:

12. Describe any pain you have from these problems. (If specialized care was received for this pain, obtain medical reports).

13. List medications you take, prescribed or over-the-counter, side effects and how often medication is taken:

14. Who prescribed the medications? (Obtain medical information)

15. Have you been treated by or referred to a(n):	YES	NO	REFERRED	TREATED
Orthopedist	☐	☐	☐	☐
Internist	☐	☐	☐	☐
Neurologist	☐	☐	☐	☐
Cardiologist	☐	☐	☐	☐
Psychologist/Psychiatrist	☐	☐	☐	☐
Other specialist	☐	☐	☐	☐

16. Have you been hospitalized due to your disability or illness? ☐ Yes ☐ No

If yes, where? _____

How long? Dates? _____

Admitting physician name? _____

Medical information **must be current** (within the past 12 months). It must include information on each of the claimant's complaints. If not current or complete, schedule an examination.

ADDITIONAL INFORMATION AND COMMENTS

ITEM NO.	

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 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	

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	

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	

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 five (5) years. If needed, use a separate sheet and attach to this form.

If you have not had any services in the last 5 years, check here: ☐ **NONE**

DO YOU HAVE A PRIMARY CARE PHYSICIAN?

☐ **YES** ☐ **NO** **If yes, list your primary care physician here:**

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
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		

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	DATE
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	DATE

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.