



### Disability Certification

To be completed by subscriber  
Failure to complete the entire questionnaire may cause a delay in eligibility qualification.

Dependent: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Identification #: \_\_\_\_\_

Group #: \_\_\_\_\_

Reference #: \_\_\_\_\_

Regardless of their current age, unmarried children may be eligible for continued dependent coverage under their parent's plan if they are covered as dependent children under their parent's health benefits (or before reaching age 26 in the absence of such coverage) if they are incapable of self-sustaining employment due to:

- Mental illness/developmental disability (as defined by NYS Mental Hygiene Law),
- Intellectual disability, or
- Physical disability

In order to determine your child's eligibility for continued coverage, please provide the information requested on this form. The reverse side should be completed and certified by your child's physician. Please return to our plan in the enclosed envelope when completed.

1. Is dependent a full time student? Yes  No

If NO, indicate last grade completed: \_\_\_\_\_

Please also indicate any special programs that have been completed.

\_\_\_\_\_

2. Name of school: \_\_\_\_\_ Grade: \_\_\_\_\_

3. Has dependent been employed full or part-time since his/her 26<sup>th</sup> birthday? Yes  No

If YES, give name, address, phone number, and dates of employment:

Name	Address	Phone	Dates
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

4. Is dependent receiving Medicare? Yes  No

If YES, please provide information from dependent's Medicare ID card:

Hospital insurance (Part A) effective date: \_\_\_\_\_

Medical insurance (Part B) effective date: \_\_\_\_\_

Medicare claim number: \_\_\_\_\_

Print subscriber name: \_\_\_\_\_

Subscriber signature: \_\_\_\_\_ Date: \_\_\_\_\_

To be completed by physician

Failure to complete the entire questionnaire may cause a delay in eligibility qualification.

Patient's name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Patient's diagnosis: \_\_\_\_\_

Type of disability (please check):

Intellectual disability     Developmental disability     Mental illness     Physical disability

**History**      Date symptoms first appeared or accident happened: \_\_\_\_\_

**Present condition**

1. At what age level does the patient function: \_\_\_\_\_
2. Patient's IQ: \_\_\_\_\_
3. Degree of physical impairment:                     None     Mild     Severe
4. Degree of psychiatric impairment:                     None     Mild     Severe
5. Has the disability existed continuously since patient's 26<sup>th</sup> birthday?                     Yes     No
6. Is patient capable of self-support?                     Yes     No
7. Is patient capable of attending school?                     Yes     No
8. Is patient:                     Ambulatory     Bed confined     House or hospital confined
9. Can patient use public transportation?                     Yes     No

**Treatment**

1. Date of last visit: \_\_\_\_\_
2. Current treatment status including mental status and physical exam:  
\_\_\_\_\_
3. Is patient involved currently in a therapy program?                     Yes     No
4. List hospitalizations, if any:  
Name: \_\_\_\_\_ Dates: \_\_\_\_\_  
Name: \_\_\_\_\_ Dates: \_\_\_\_\_

**Prognosis**

1. Will the patient make any significant physical or mental progress with continued therapies that would improve his or her functional status?                     Yes     No
2. Please estimate period patient will remain totally disabled:

Print physician's name: \_\_\_\_\_  
Physician's signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_