# Disability Eligibility Determination Form

**TO BE COMPLETED BY PRIMARY CARE PHYSICIAN**

Patient Name:

Date of Birth: Member Number:

1. Date at which patient became disabled.________________________________
2. Do you consider this a permanent disability? ☐ Yes ☐ No

   If no, please indicate the expected length of the disability. _____________________________________
3. Diagnosis ____________________________________________________________
4. At what age was this disability manifested? __________________________
5. Is this disability the result of a (p*lease check all that apply*):

   ☐ Mental illness ☐ Developmental disability
   ☐ Mental retardation ☐ Physical handicap
   ☐ Other, (please explain) ___________________________________________
6. Please describe (or provide documentation) of the patient's current cognitive functioning level. *(if applicable)*

   ________________________________________________________________________________________

   ________________________________________________________________________________________
7. Patient's IQ ______ Testing method utilized ___________________________________________
8. Please describe (or provide documentation) of the patient's education and level of training. (*if applicable*)

   ________________________________________________________________________________________

   ________________________________________________________________________________________

   ________________________________________________________________________________________
9. Please describe the patient's work history:___________________________________________

   ________________________________________________________________________________________

   ________________________________________________________________________________________

   ________________________________________________________________________________________
10. Please describe (or provide documentation) of the patient's physical handicap and the extent of physical functioning. (*i.e. is the patient ambulatory, what is the level of upper and lower body functioning, etc.*)

    ________________________________________________________________________________________

    ________________________________________________________________________________________

    ________________________________________________________________________________________

Please attach the following information:

- A complete history including a current physical outlining the patient's disability
- A current cognitive functioning level and current vocational assessment.
- Current supporting documentation from specialty care physicians that is appropriate.

Physician's Signature ________________________________________________ Date _________________