Center for Independence

1-2017, Val

Grand Junction 970-241-0315, Montrose 970-249-3783, Glenwood 970-718-5515, or 1-800-613-2271

Request For Help With A Disability Claim

Date: _____ ANSWER **ALL** QUESTIONS **COMPLETELY** TO THE BEST OF YOUR ABILITY

Name of person interested in services (Applicant): _____ Date of Birth _____

Name of person and or Agency making the referral: _____

How the person making the referral can be contacted: _____

1. Is the applicant between the ages of 17 ½ to 65 years old? Yes ____ No ____
2. Is the applicant a resident of: Chaffee, Delta, Eagle, Garfield, Gunnison, Hinsdale, Lake, Mesa, Montrose, Ouray, Pitkin, or San Miguel County? Yes ____ No ____
3. Does the applicant have a medical condition (Physical or Mental) or combination that is expected to last 12 months or results in death and interferes with working? Yes ____ No ____
4. Is the applicant a United States citizen or a documented, permanent resident? Yes ____ No ____
5. Does the applicant have an active application with Social Security or currently in the Social Security Disability benefits appeal process? Yes ____ No ____
6. Is the applicant currently working with an attorney, or other professional, on an SSI/SSDI application? Yes ____ No ____
7. Does applicant earn less than $1180.00 (or $1970.00 with a vision disability) per month? Yes ____ No ____ 9-10-11-12 - 13-14-15-16
8. What was the highest grade completed in school? High School _____ College _____
9. Has the applicant been turned down for SSI/SSDI? Yes ____ No ____ **Date last denied** _____
10. Has the applicant been turned down for Aid to the Needy and Disabled (AND)? Yes ____ No ____

Applicant Name (first, middle, last)	Best Way to Be Reached
Street Address	**Back-up Person to Reach Applicant**
City, State, Zip	**Contact Information for Back-up**

Medical/Mental Health Services Screening

The Social Security Administration (SSA) defines disability as having a physical or mental condition, or combination, that prevents an individual (or is expected to prevent) the individual from earning $1180.00 per month (2018), or $1970.00 per month for someone with a vision disability, for at least 12 months. There must be evidence of the individual's medical or mental health diagnosis and how the condition prevents them from working.

Screening Questions for Medical and Mental Health Services

1. Tell us about health challenges. Please list the different health challenges.
    a. Health Challenge:

    b. Health Challenge:

    c. Health Challenge:

    d. Health Challenge:

2. Tell us about where you receive health services for each health challenge.
    a. Treatment Provider:

    b. Treatment Provider:

    c. Treatment Provider:

    d. Treatment Provider:

3. Additional connections for medical and mental health services:
    a. Treatment Provider:
    b. Treatment Provider:
    c. Treatment Provider:
    d. Treatment Provider

Additional Screening Questions related to SSI/SSDI Eligibility

1. Please describe if your medical condition is expected to last for 12 months and if it is expected to stay the same; get better; or get worse.

_____
_____
_____
_____

2. Please identify your medical condition(s) that prevent you from working. Be detailed and specific. Use additional sheets of paper if necessary to fully answer questions.

_____

_____

_____

3. Please tell us the last time you worked, where you worked and the date of the last day worked.

_____
_____
_____
_____
_____

4. Please tell us the reason(s) that you stopped working.

_____
_____
_____
_____
_____

5. Please tell us what is currently making it difficult for you to work and keep a job.

_____
_____
_____

6. Have you worked 5 years out of the last 10 years? Yes ____ No ____

7. List the jobs you have had during the last 15 years? List the type of business where you worked, your job title, hours worked per week, and the start and end dates when you were employed.

TYPE OF BUSINESS	JOB TITLE	HOURS WORKED PER WEEK	DATES WORKED

Please circle any services you are currently receiving:

SSI SSDI Medicaid Medicare VA AND Food Stamps OAP TANF

1. Does the applicant have any other income or assets? Yes ____ No ____ If yes, list and explain. Such as collectibles, vehicles, boats, recreational vehicles, Certificates of Deposit (CD's), life insurance; basically anything that can be sold for value.

_____
_____
_____

2. Please list and describe your health symptoms and when they began? Symptoms create the limitations which are preventing your ability to work and earn $1180.00 per month or $1970.00 with a vision disability.

_____
_____
_____
_____
_____
_____

Substance Abuse History:

1. Does the applicant have a history of alcohol or drug abuse? Yes ____ No ____ If yes, what substances?

_____
_____

2. Is the applicant currently using any non-prescribed drugs or alcohol? Yes ____ No ____ If yes, what and how often?

_____
_____
_____

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Treatment History Form

Treatment Facility	From To	Reason(s) for Treatment

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Medication Form

Medication	Dose	Purpose	Side Effect

Please start gathering the medical records that support the claim for disability. The medical records will be needed in order to fill out the forms to process your claim.