

ADRC REFERRAL AND DETERMINATION

PART I: REFERRAL TO MQD/MSB: ADRC COORDINATOR

DATE: ___/___/___

1. APPLICANT/CLIENT NAME _____ DATE OF BIRTH ___/___/___

DHS CASE NO. _____ DHS CLIENT NO. _____

2. TYPE OF REFERRAL:

ADRC INITIAL DETERMINATION

ADRC REDETERMINATION DATE LAST ADRC COMPLETED: ___/___/___

3. REFERRAL SOURCE:

DHS: _____
Division / Section / Unit Name of EW Phone No. Fax No.

QUEST HEALTH PLAN: _____
Name of Plan Contact Person Phone No. Fax No.

4. DHS 1127, MEDICAL HISTORY AND DISABILITY STATEMENT

DHS 1128, DISABILITY REPORT

DHS 1147, SUB-ACUTE/LONG TERM CARE/HOSPICE LEVEL OF CARE EVALUATION, **IF APPLICABLE,**
AND

ADDITIONAL INFORMATION OR SUPPORTING EVIDENCE FOR PHYSICAL DISABILITY FROM THE QUEST HEALTH PLAN OR MEDICAL PROVIDER.

COMMENTS: _____
_____.

PART II: DETERMINATION BY MQD/MSB:

ADRC

1. UNIT: _____ WORKER: _____

QUEST HEALTH PLAN: _____ CONTACT PERSON: _____

2. ADRC DETERMINATION:

CONDITION IS PERMANENT.

DISABLED. MEETS SSI DISABILITY CRITERIA. (Referral To SSA. Disenrollment from QUEST Health Plan, as needed.)

COMMENTS: _____
_____.

NOT DISABLED. DOES NOT MEET SSI DISABILITY CRITERIA.

COMMENTS: _____
_____.

CERTIFIED BY: _____
Medical/Psychiatric Consultant Date

3. GAINFUL ACTIVITY DETERMINATION:

DISABILITY DETERMINATION CONFIRMS GAINFUL ACTIVITY IS NOT POSSIBLE.

CONFIRMS DETERMINATION NOT DISABLED.

COMMENTS: _____
_____.

CERTIFIED BY: _____
ADRC Social Worker Date