Washington State Department of Social & Health Services

Transforming lives

Disability Report

Medical Disability Decision

DSHS 14-144A

The Disability Report form, DSHS 14-144A, gathers information about a client's disability, medical evidence, and work history for use by the Division of Disability Determination (DDDS) in determining medical disability.

The Social Service Specialist (SSS) or Financial Service Specialist (FSS) initiates the DSHS 14-144A. The SSS or FSS should ensure that the Community Service Office (CSO), and telephone number are noted on the form. Check the appropriate box to indicate that the disability decision requested is for Non-Grant Medical Assistance (NGMA) or Healthcare for Workers with Disabilities (HWD). Add the completed form to the disability decision packet.

1. The SSS or FSS completes the heading to indicate the name, Social Security Number (SSN), and disabling condition of the client.

2. The SSS or FSS may assist the client to complete Part 1 - Information About Your Condition. Dates need not be exact, but should reflect month and year.

3. The SSS or FSS may assist the client to complete Part 2 - Information About Your Medical Records. It is important to identify physicians and treatment sources as completely as possible.

4. The SSS or FSS may assist the client to complete Part 3 - Information About Your Activities. The SSS or FSS should review information to ensure client's limitations are clearly identified.

5. The SSS or FSS may assist the client to complete Part 4- Information About Your Education. It should be noted if school classes were Special Education classes.

6. The SSS or FSS may assist the client to complete Part 5 - Information About the Work You Did. Individual employers should not be listed, only the type of business.

7. The SSS or FSS may assist the client to complete Item 1 in Part 6 - Remarks. Items 2 through 6 are to be completed by the SSS or FSS.

Washington State Department of Social & Health Services
Transforming lives

Disability Report

Medical Disability Decision

Request is for:

- ☐ Non-Grant Medical Assistance (NGMA)
- ☐ Healthcare for Workers with Disabilities (HWD)

This form is completed by a DSHS social services or financial worker during an interview with the claimant or claimant's representative. **Please print, type, or write clearly and answer all items to the best of your ability. Answer all questions. Complete answers help process the claim. If you need more space to answer any of the questions in the form, go to part 6 or attach I sheets.**

1. CLAIMANT'S NAME / ALIAS

2. SOCIAL SECURITY NUMBER

3. TELEPHONE NUMBER (AND AREA CODE)

4. THIRD PARTY CONTACT
   - NAME
   - TELEPHONE NUMBER (AND AREA CODE)
   - ADDRESS

5. WHAT IS YOUR DISABLING CONDITION? BRIEFLY EXPLAIN THE INJURY OR ILLNESS THAT PREVENTS YOU FROM WORKING.

Part 1. Information About Your Condition

YES NO

1. What date did your condition first bother you?

   _____

   MONTH, DAY, YEAR

2A. Did you work after the date shown in item 1 above? If you answered **NO**, go to 3A and 3B. below. ..... ☐ ☐

2B. **If you answered yes to 2A,** did your condition cause you to change:

Your job or job duties? ..... ☐ ☐

Your hours of work? ..... ☐ ☐

Your attendance? ..... ☐ ☐

Anything else about your work? ..... ☐ ☐

2C. **If you answered yes to any item in 2B,** explain what the changes in your work circumstances were, the dates they occurred, and how your condition made these changes necessary:

3A. When did your condition finally make you stop working?

_____

MONTH, DAY, YEAR

3B. Explain how your condition now keeps you from working:

Part 2. Information About Your Medical Records

1. Enter the following information about the doctor who has the latest medical records about your disabling condition:	☐ **Check here if you have never seen a doctor for your disabling condition.**
DOCTOR'S NAME / CLINIC	
TELEPHONE NUMBER (AND AREA CODE)	
ADDRESS	
DATE YOU FIRST SAW THIS DOCTOR	
ILLNESS OR INJURY FOR WHICH YOU HAD AN EXAMINATION OR TREATMENT	
DATE YOU LAST SAW THIS DOCTOR	

TYPE OF TREATMENT OR MEDICINES RECEIVED (I.E., SURGERY, CHEMOTHERAPY, RADIATION, AND THE MEDICINES YOU TAKE FOR YOUR ILLNESS OR INJURY, IF KNOWN. IF NO TREATMENT OR MEDICINES, WRITE NONE.
2. Have you seen any other doctors since your disabling condition began? ☐ Yes ☐ No **If yes, answer the following:**
DOCTOR'S NAME / CLINIC
TELEPHONE NUMBER (AND AREA CODE)
ADDRESS
DATE YOU FIRST SAW THIS DOCTOR
ILLNESS OR INJURY FOR WHICH YOU HAD AN EXAMINATION OR TREATMENT
DATE YOU LAST SAW THIS DOCTOR

TYPE OF TREATMENT OR MEDICINES RECEIVED (I.E., SURGERY, CHEMOTHERAPY, RADIATION, AND THE MEDICINES YOU TAKE FOR YOUR ILLNESS OR INJURY, IF KNOWN. IF NO TREATMENT OR MEDICINES, WRITE NONE.
If you have seen additional doctors since this illness or injury, attach additional pages with the above information.
3. Have you been treated at a hospital for your disabling condition? ☐ Yes ☐ No **If yes, answer the following:**
NAME OF HOSPITAL
TELEPHONE NUMBER (AND AREA CODE)
ADDRESS
WHAT WERE THE DATES OF YOUR VISITS?
ILLNESS OR INJURY FOR WHICH YOU HAD AN EXAMINATION OR TREATMENT

TYPE OF TREATMENT OR MEDICINES RECEIVED (I.E., SURGERY, CHEMOTHERAPY, RADIATION, AND THE MEDICINES YOU TAKE FOR YOUR ILLNESS OR INJURY, IF KNOWN. IF NO TREATMENT OR MEDICINES, WRITE NONE.
4. If you have been in other hospitals for your illness or injury, answer the following:
NAME OF HOSPITAL
TELEPHONE NUMBER (AND AREA CODE)
ADDRESS
WHAT WERE THE DATES OF YOUR VISITS?
ILLNESS OR INJURY FOR WHICH YOU HAD AN EXAMINATION OR TREATMENT
TYPE OF TREATMENT OR MEDICINES RECEIVED (I.E., SURGERY, CHEMOTHERAPY, RADIATION, AND THE MEDICINES YOU TAKE FOR YOUR ILLNESS OR INJURY, IF KNOWN. IF NO TREATMENT OR MEDICINES, WRITE NONE.

If you have been in other hospitals or clinics for your illness or injury, list the names, dates and reasons in Part 6 or attach additional pages.

5. Have you had any of the following tests in the last year? Check the appropriate box below and, if you answer "yes," give where and when the test was done.

TEST	YES	NO	WHERE DONE	WHEN DONE
Electrocardiogram	☐	☐		
Chest X-ray	☐	☐		
Other x-ray (specify type):	☐	☐		
Breathing tests	☐	☐		
Blood tests	☐	☐		
Other (specify):	☐	☐		

Part 3. Medication List

NAME OF MEDICATION	PRESCRIBED BY (NAME OF DOCTOR)	REASON FOR MEDICATION

If you use more medications, attach additional pages with the above information.

Part 4. Information About Your Education

1. **What is the highest grade of school that you completed?**
   _____ What year? _____
2. Have you gone to trade or vocational school or had any type of special training? ☐ Yes ☐ No
   If yes, answer the following:

TYPE OF TRADE OR VOCATIONAL SCHOOL OR TRAINING
APPROXIMATE DATES YOU ATTENDED
HOW THIS SCHOOLING OR TRAINING WAS USED IN ANY WORK YOU DID

If the client is attending school, please provide the following.

SCHOOL NAME, ADDRESS, AND PHONE NUMBER
TEACHER'S NAME

Part 5. Information About the Work You Did

List all jobs you have had in the last 15 years before you stopped working, beginning with your usual job. This means the kind of work you did the longest. If you have 6th grade education or less, AND did only heavy unskilled labor for 35

years or more, list all of the jobs you have had since you began to work. If you need more space, either attach additional pages or use Part 6.

JOB TITLE	TYPE OF BUSINESS	FROM	TO	DAYS PER WEEK	RATE OF PAY (PER HOUR, DAY, WEEK, MONTH, OR YEAR)

2A. In your usual job listed above, did you:

	YES	NO
Use machines, tools, or equipment of any kind?	☐	☐
Use technical knowledge or skills?	☐	☐
Do any writing, complete reports, or perform similar duties?	☐	☐
Have supervisory responsibilities:	☐	☐

2B. Explain all yes answers by giving a full description of: the types of machines, tools, or equipment you used and the exact operation you performed; the technical knowledge or skills involved; the type of writing you did,

and the nature of any reports; and the number of people you supervised and the extent of your supervision.

2C. Describe the kind and amount of physical activity your usual job involved during a typical day by checking the best answer below.

How many hours a day did you:

Walk?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
	☐ 6	☐ 7	☐ 8			
Stand?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
	☐ 6	☐ 7	☐ 8			
Sit?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
	☐ 6	☐ 7	☐ 8			

How often a day did you:

Bend?

☐ Never ☐ Occasionally ☐ Frequently ☐ Constantly

Reach?

☐ Never ☐ Occasionally ☐ Frequently ☐ Constantly

Lifting and carrying: describe what was lifted and how far it was carried:

What was the heaviest weight you lifted? ☐ 10 lbs. ☐ 20 lbs. ☐ 50 lbs. ☐ 100 lbs. ☐ Over 100 lbs.

What was the weight you frequently lifted or carried?

☐ Up to 10 lbs. ☐ Up to 25 lbs. ☐ Up to 50 lbs.
☐ Up to 100 lbs.

Part 6. Remarks

1. Use this section for additional space to answer any previous questions. Also, use this space to give any additional information that you think will be helpful in making a decision in your disability claim (such as information about other illnesses or injuries not listed previously).

To be Completed by Interviewer

2. Does the claimant speak English? ☐ Yes ☐ No
   If no, what language doe he/she speak:
3. Does the claimant need assistance processing his or her claim? ☐ Yes ☐ No
   If yes, complete the third party contact on Page 1.
4. Check which difficulties below, if any, were observed while interviewing the claimant.

   ☐ Reading ☐ Writing ☐ Answering questions
   ☐ Hearing ☐ Sitting ☐ Understanding
   ☐ Using hands ☐ Breathing ☐ Seeing ☐ Walking
   ☐ Other (specify):
   ☐ NONE OBSERVED

   If any of the above items were checked, describe the exact difficulty involved:

5. Any pending / current ABD evaluations?
   - ☐ Yes ☐ No
   - ☐ Physical; date: _____
   - ☐ Mental Health; date: _____
6. Describe the claimant fully (e.g., general build, height, weight, behavior, any difficulties that add to or supplement those noted above):

INTERVIEWER'S SIGNATURE	DATE
INTERVIEWER'S NAME (TYPE OR PRINT)	
INTERVIEWER'S TELEPHONE NUMBER (AND AREA CODE)	
COMMUNITY SERVICES OFFICE	