



## Instructions for Completing Handicap Waiver Request

As indicated by Section III.A.2.e of the CDPHP membership certificate, a subscriber's unmarried child age 19 or older may be enrolled as a dependent if he or she is:

*Incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation, as defined in the New York Mental Hygiene Law, or physical handicap, and became so incapable prior to age 19 . . . and chiefly dependent upon the Subscriber for support and maintenance.*

The *Handicap Waiver Request* may be used to provide evidence of the dependent's handicapping conditions. The form must be completed and signed by the applicant's primary care physician, specialist, or psychiatric provider.

It should be accompanied by the subscriber's most recent federal tax income form (or other equivalent documentation) verifying the subscriber's continued responsibility for the dependent's support and maintenance. The financial specifics on the documentation may be concealed for privacy purposes.

The completed *Handicap Waiver Request* and support documentation should be returned to:

CDPHP Enrollment Department  
500 Patroon Creek Blvd.  
Albany, NY 12206



500 Patroon Creek Blvd. • Albany, NY 12206-1057  
(518) 641-4100 • 1-800-274-2332

## Handicap Waiver Request

Please submit Release of Information Form with this request.

Applicant's primary care physician, specialist or psychiatric provider may complete this Handicap Waiver Form. Additional information regarding applicant's functional status may be obtained and submitted from any of the following sources:

- Psychiatrist/psychologist • Social worker • School psychologist • Individualized Education Plan (IEP)

### I. General Information:

_____	_____
Date	Name of dependant/applicant
_____	_____
Residence of applicant	Phone number
_____	_____
Date of birth	Parent/guardian
_____	_____
CDPHP ID #	Secondary coverage

### II. Employment Information:

Is the applicant employed?  Yes  No

If yes: Number of hours/week: \_\_\_\_\_

Name/address of employer \_\_\_\_\_

Types of work/duties performed: \_\_\_\_\_

If no: Reason why unable to work: \_\_\_\_\_

Is a job coach involved with member for employment skills?  Yes  No

### III. Education Information:

Does the applicant attend school/college?  Yes  No

If yes: Number of classes per day: \_\_\_\_\_

Name of school/college attended: \_\_\_\_\_

Did applicant have an Individualized Education Plan (IEP)?  Yes (Please submit copy.)  No

I.Q. (if applicable): \_\_\_\_\_

If no: Highest grade completed: \_\_\_\_\_

Reason why member does not attend school: \_\_\_\_\_

### IV. Medical Information:

Handicap diagnosis: \_\_\_\_\_

\_\_\_\_\_

Date of condition onset: \_\_\_\_\_

Date of last exam (must be within past 12 months): \_\_\_\_\_

Frequency of visits (please check one):

- Every month  Every 2 months  Every 3 months  Every 6 months  Once a year

(continued on other side)

**IV. Medical Information:** *(continued from other side)*

Check ALL that apply in support of handicap status:

**Musculoskeletal system:**

- Amputation                       Right    Arm    Leg                       Left    Arm    Leg
- Loss of function                 Right    Arm    Leg                       Left    Arm    Leg

**Describe impairment**

- Limited range of motion . . . . . \_\_\_\_\_
- Sensory or reflex changes . . . . . \_\_\_\_\_
- Circulatory deficits . . . . . \_\_\_\_\_

**Sensory impairments:**

- Vision . . . . . \_\_\_\_\_
- Hearing . . . . . \_\_\_\_\_
- Speech . . . . . \_\_\_\_\_

**Respiratory system:** . . . . . \_\_\_\_\_

**Cardiovascular system:** . . . . . \_\_\_\_\_

**Other:**

Please describe any medical findings not listed above. **MUST INCLUDE** diagnosis, date of onset, and clinical findings.

\_\_\_\_\_  
\_\_\_\_\_

**V. Mental health information:**

Diagnosis: \_\_\_\_\_

Date of onset: \_\_\_\_\_

**Please submit current psychological evaluation (if applicable)**

Cognitive abilities:

- Disorientated to time/place    Memory impairment    Short term    Intermediate    Long term

Perceptual or thinking disturbances:

- Hallucinations    Delusions    Change in personality    Mood disturbance    Emotional liability
- Other: \_\_\_\_\_

**VI. Summary:**

Describe how the functional activities of daily living are affected by this impairment: \_\_\_\_\_

\_\_\_\_\_

Current treatment, response to treatment and expected outcome: \_\_\_\_\_

\_\_\_\_\_

Current medications: \_\_\_\_\_

\_\_\_\_\_

Anticipated duration of condition:

- Temporary (must be 12 months or more):
  - 12 months    18 months    24 months
- Permanent

Please sign certification:

I \_\_\_\_\_, a duly licensed physician hereby declare that \_\_\_\_\_ is incapable of self sustaining employment by reason of above noted mental illness, developmental disability, mental retardation or physical handicap and is chiefly dependent upon the subscriber \_\_\_\_\_, for support and maintenance.

**Physician signature:** \_\_\_\_\_

**Address:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Phone number:** \_\_\_\_\_