



Instructions for Completing Disability Waiver Request

As indicated by Section V (Who is Covered) 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, intellectual disability (as defined in the New York Mental Hygiene Law), or physical disability and who became so incapable prior to attainment of the age at which the Child's coverage would otherwise terminate and who is chiefly dependent upon You for support and maintenance, will remain covered while Your insurance remains in force and Your Child remains in such condition. You have 31 days from the date of Your Child's attainment of the termination age to submit an application to request that the Child be included in Your coverage and proof of the Child's incapacity. We have the right to check whether a Child qualifies and continues to qualify under this section.

The *Disability Waiver Request* may be used to provide evidence of the dependent's disabling 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 *Disability 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

Disability Waiver Request

Please submit Release of Information Form with this request.

Applicant's primary care physician, specialist or psychiatric provider may complete this Disability 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:

Disability 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 disability 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, intellectual disability or physical disability and is chiefly dependent upon the subscriber _____, for support and maintenance.

Physician signature: _____

Address: _____

Phone number: _____