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
6 Wellness Way
Latham, NY 12110

6 Wellness Way • Latham, NY 12110
(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: _____