

How often do you see this doctor?

Date you were last seen by this doctor.

Describe the reason you were / are being seen by this doctor.

Describe the type of treatment, surgery or medications received.

If you have seen more than one doctor, list the additional information here.

Doctor's Name

Telephone Number

Doctor's Address

How often do you see this doctor?

Date your were last seen by this doctor.

Describe the reason you were / are being seen by this doctor.

Describe the type of treatment, surgery or medications received.

Have you been hospitalized or treated at a clinic for your disability in the last 12-months?

Yes No If "Yes", complete below. If "No", go to Section V.

Name of Hospital or Clinic

Patient Number

Address of Hospital or Clinic

Were you an inpatient (stayed overnight at least one night)? Yes No If "Yes", complete below.

What was the date that you were admitted?

What is the date that you were discharged?

Were you an outpatient? Yes No If "Yes", list the dates that you were seen.

Describe the reason for your hospitalization or clinic visits.

Describe the type of treatment, surgery or medications that you received.

Have you had any of the following tests in the last 12-months?

Test		Date of test	Facility where test was done
Electrocardiogram (EKG)	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Chest X-Ray	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Other X-Ray (describe below)	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Breathing Test	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Blood Test (describe below)	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Other Test (describe below)	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Describe the types of test you received.

Describe the daily activities you do that are listed below. Indicate which activities you do and how often they are done.

Household Maintenance (including cooking, cleaning, shopping and odd jobs around your house as well as including similar activities)

Recreational Activities and Hobbies (such as hunting, fishing, bowling, hiking, musical activities)

Social Contact (such as visits with friends, relatives, neighbors)

Other Activities (such as drive car or motorcycle, ride bus)

Has your doctor limited any of the activities that you listed above? Yes No. If Yes", describe the limitations.

Have you been seen by other agencies (Veteran's Administration, Worker's Compensation, Vocational Rehabilitation or Social Services, etc) for your disabling condition? Yes No If "Yes", complete the following:

Name of Agency

Claim Number

Dates of Visits

Describe services, treatment, surgery or medication received.

SECTION V - WORK HISTORY

Are you currently working? Yes No If "Yes", complete below. If "No", go to Section VI.

Name of Employer

Address of Employer

Job Title

Date of Hire

Hours work per week

Rate of Pay \$

SECTION VI - EDUCATION INFORMATION

Have you attended (trade, vocational or academic) school or had any other type of training since you began receiving Medicaid? Yes No If "Yes", complete below. If "No", go to Section VII.

Describe type of training

Are you attending school? Yes No

What grade are you currently in?

Name of School

Address of School

SECTION VII – ADDITIONAL INFORMATION

Use this section for additional information that you think will be helpful in making a decision in your Medicaid Disability redetermination, or to answer any previous question where additional space was needed. List information such as other illnesses or injuries not listed in previous sections, other doctors that you have seen or hospitalizations that you have not previously described. Please refer to the previous section numbers when describing additional information.

SECTION VIII SIGNATURE OF RECIPIENT / AUTHORIZED REPRESENTATIVE

I understand the questions and statements on this report. I understand the penalties for giving false information or breaking rules. I certify, under penalty of false swearing, that all my answers are complete to the best of my knowledge. I understand that the agency may contact other persons or organizations to obtain the necessary proof of my eligibility and level of benefits. (The recipient's signature must be witnessed by two people if signed with an "X".)

SIGNATURE - Name of recipient or authorized representative	Date Signed
SIGNATURE – Witness	Date Signed
SIGNATURE – Witness	Date Signed

SECTION VIII – AUTHORIZATION OF REPRESENTATION

This section must be completed by the person who completed this Medicaid Disability Redetermination report on behalf of a recipient. Documentation must be provided to the recipient’s local county/tribal social or human or services agency.

Did you complete a Medicaid Disability Redetermination report on behalf of another person and are you that person’s court appointed guardian, conservator or have durable power of attorney for health care for that person?

Yes No

If you answered “Yes”, stop here. You must submit, to the local county/tribal social or human services agency, the legal documentation authorizing you to be that person’s appointed guardian or durable power of attorney for finances.

Are you an authorized representative completing the Medicaid Disability Redetermination report for another person?

Yes No

If you are an Authorized Representative, then:

1. You and the recipient must complete the information below.
2. Both you and the recipient must sign the Signature Section of this report.
3. Both you and the recipient must sign this report in order for you to be an authorized representative.

Name - Authorized Representative (Last, First, MI)	Telephone Number ()
Address (Street, City, State, Zip Code)	E-mail Address (Optional)

I authorize _____ (name of representative) to represent me in my Medicaid Disability Redetermination report to be filed with the county/tribal social or human services agency administering the program and in the reviews of my eligibility. I also authorize my representative to provide information and documents which may be necessary to establish my disability redetermination. I will provide information to my representative that will be true and correct to the best of my knowledge. My representative and I understand that penalties for providing fraudulent information could be a fine of up to \$25,000, imprisoned up to seven years and six months, or both and suspended from Wisconsin Medicaid (NOTE: Someone other than your representative must witness your signature. Two witness signatures are required if you sign with an “X”).

SIGNATURE – Recipient / Representative / Guardian / Health Care Power of Attorney / Conservator	Date Signed
SIGNATURE – Witness	Date Signed
SIGNATURE – Witness	Date Signed

As an authorized representative I understand that I am representing the above named recipient for Medicaid Disability redetermination and that information provided is true and correct to the best of my knowledge.

SIGNATURE – Authorized Representative	Date Signed
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SECTION VIII - OFFICE USE ONLY

INFORMATION TO BE COMPLETED BY THE INTERVIEWER. THE INTERVIEWER SHOULD BE A SUPPORTIVE SERVICES PLANNER OR SOCIAL WORKER.

Does the recipient need assistance processing this claim? Yes No

If yes, list name, address, and telephone number of the person who will assist the recipient.

Name (Last, First, MI)	Relationship
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Address (Street, City, State, Zip Code)	Telephone Number
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Can the recipient speak English? <input type="checkbox"/> Yes <input type="checkbox"/> No	If recipient cannot speak English, what language can the recipient speak?
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Can the recipient read English? <input type="checkbox"/> Yes <input type="checkbox"/> No	Can the recipient write in English (Other than his/her name)? <input type="checkbox"/> Yes <input type="checkbox"/> No
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If the recipient cannot speak English list the name of someone that may be contacted who speaks English and will give the recipient messages.

Name (Last, First, MI)	Relationship to Recipient
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Address (Street, City, State, Zip Code)	Daytime Telephone Number
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Describe the recipient fully (e.g. general build, height, weight, behavior, grooming and any problems with the ability to read, write, answer, hear, sit, understand, use hands, breathe, see or walk.)

Print Name - Interviewer	Title of Interviewer
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SIGNATURE - Interviewer	Date Signed
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Office Address (Street, City, State, Zip Code)	Telephone Number
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Email Address	Fax Number
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