NEW YORK STATE
OFFICE OF TEMPORARY AND DISABILITY ASSISTANCE
40 NORTH PEARL STREET
ALBANY, NY 12243-0001
David A. Paterson
Governor

Informational Letter

Section 1

Transmittal:	10-INF-13
To:	Local District Commissioners
Issuing Division/Office	Center for Employment and Economic Supports
Date:	July 16, 2010
Subject:	Revised LDSS-4526 (Rev. 6/2010) Medical Examination for Employability Assessment, Disability Screening, and Alcoholism/Drug Addiction Determination and Release of Cover Letter to Accompany the Request for Medical Information Model Document
Suggested Distribution:	Income Maintenance Directors Employment Coordinators
Contact Person(s):	Employment Questions: Employment Services Advisor or the Employment and Advancement Services Bureau at (518) 486-6106 Temporary Assistance Program Questions: Bureau of Temporary Assistance at (518) 474-9344
Attachments:	Attachment 1: LDSS-4526 Medical Examination for Employability Assessment, Disability Screening, and Alcoholism/Drug Addiction Determination Attachment 2: Cover Letter to Accompany the Request for Medical Information Model Document
Attachment Available On – Line:	☒

Filing References

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
01 ADM 3		18 NYCRR 385.2 351.2 369.4 370.4	332, 332-b	Temporary Assistance and Food Stamp Employment Manual Section 2 and Section 15	

I. Purpose

The purpose of this release is to provide revisions to the LDSS-4526 (Rev. 6/2010*) Medical Examination for Employability Assessment, Disability Screening, and Alcoholism/Drug Addiction Determination.* The revisions are intended to collect information about the type and length of conditions and resulting limitations identified on the form. The changes also delete the "Limitations Resulting from Recent Addiction Behavior" section. Additionally, we are introducing the *Cover Letter to Accompany the Request for Medical Information* Model Document.

II. Background

Prior to these changes to the LDSS-4526, the form did not specifically solicit information describing how long medical conditions and limitations were expected to last or whether a diagnosis is related to physical health, mental health, a substance use disorder or some other condition. The changes introduced with this release now collect such information. Specifically, the following changes were made:

- Section III (Medical Information) asks for information describing how long each identified condition is expected to last;
- Section III (Medical Information) asks the evaluator to indicate whether each medical condition identified relates to physical health, mental health, a substance use disorder or some other type of diagnosis;
- Section VII b (Limitations on Work Activities) asks the length of time restrictions identified in VII a are expected to last;
- Deleted "SSN#" entry from Section 1;
- Deleted the question "Does the client have an active SSI application pending?"
- Deleted the "Limitations Resulting from Recent Addiction Behavior" section; and,
- Deleted the question "If a Veteran, has this person been referred to the Veteran's Administration?"

The *Cover Letter to Accompany the Request for Medical Information* has been developed as a model document to accompany the LDSS-4526 and will be available in Section 15 of the Temporary Assistance and Food Stamps Employment Policy Manual. Districts may choose to use the model document or local equivalent as a cover letter to explain the purpose of the request for medical information and how the information will be used. Districts are not required to use the model document, but may do so whenever they feel that the cover letter will facilitate the return of the most complete and relevant information solicited through the LDSS-4526 or a local equivalent medical form.

III. Program Implications

Districts should begin to use the revised LDSS-4526 (Rev. 6/2010) upon this release and the *Cover Letter to Accompany the Request for Medical Information* Model Document as they determine appropriate. The LDSS-4526 (Rev. 6/2010) has also been added to Intelligent Auto Fill (IAF) and is available for use upon this release. Districts that wish to use the *Cover Letter to Accompany the Request for Medical Information* Model Document must produce the form locally and may alter the attached Word version to suit local needs.

IV. Forms Ordering Information

The revised English version of the LDSS-4526: *"Medical Examination for Employability Assessment, Disability Screening and Drug/Alcoholism Addiction Determination"* is **not** a State printed form but is available to local districts in PDF format or as master camera ready copies. The procedures for ordering PDFs or master camera ready copies are listed below.

The above referenced document has also been posted on the OTDA Intranet website at http://otda.state.nyenet/ldss_eforms/default.htm and is available for downloading by local districts for reproduction locally.

Upon the release of this INF all previous versions of the *"Medical Examination for Employability Assessment, Disability Screen and Drug/Alcoholism Addition Determination"* **must immediately be destroyed** and replaced with the revised 6/10 version.

Any future written requests for master camera ready copies of the English version of the document should be submitted on OTDA-876: *"Request for Forms or Publications"*, and sent to:

Office of Temporary and Disability Assistance
BMS Document Services and Operational Support
PO Box 1990
Albany, NY 12201

Questions concerning ordering forms should be directed to BMS Document Services at 1-800-343-8859, ext. 4-9522.

Master camera ready copies of the documents may also be ordered through Outlook. To order a master camera ready copy you must obtain an OTDA-876 electronically by going to the OTDA Intranet Website at http://otda.state.nyenet/ then to Division of Operations and Program Support page, then to PSQI E-forms page (this page contains the electronic OTDA-876).

For those who do not have Outlook but who have Internet access for sending and receiving e-mail, the Internet e-mail address is: gg7359@dfa.state.ny.us . For a complete list of available forms, please refer to the OTDA Intranet site: http://otda.state.nyenet/ldss_eforms/default.htm .

Issued By
Name: Russell Sykes
Title: Deputy Commissioner
Division/Office: Center for Employment and Economic Supports

MEDICAL EXAMINATION FOR EMPLOYABILITY ASSESSMENT, DISABILITY SCREENING, AND ALCOHOLISM/DRUG ADDICTION DETERMINATION

I. CLIENT IDENTIFICATION

Print Client Name: ______________________________ Veteran: ☐ Yes ☐ No

Address: ______________________________

Case #: ____________________ CIN: ____________________ DOB: ____________________

Reason(s) for referral: Client states that: ______________________________

____

II. AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I authorize the examining physician to disclose to the Department of Social Services any information provided, any diagnoses made, conditions revealed, and functional limitations identified, as a result of the examination given. I understand that this information will be treated as confidential.

Client Signature **x** ______________________________ Date: ________________

AUTORIZACION PARA DAR A CONOCER INFORMACION MEDICA

Yo autorizo al médico que me está examinando a dar a conocer al Departamento de Servicios Sociales cualquier información provista, cualquier diagnosis, condiciones reveladas y limitaciones funcionales identificadas en base al examen realizado. Comprendo que esta información será confidencial.

Firma del Cliente **x** ______________________________ Fecha: ________________

III. MEDICAL INFORMATION

List All Medical Conditions. Include psychiatric and alcohol/drug addiction diagnosis using DSM-IV format. (List all medical diagnoses and specify medical/clinical findings, including prognoses and how long each condition is expected to last.)

Medical Condition	**Prognosis and Treatment Recommendations including prescribed medications**	**Date of original diagnosis/diagnosis type**	**Expected Duration From Present (Months)**
		Date: ☐ Physical Health ☐ Mental Health ☐ Substance Use Disorder ☐ Other	☐1-3 ☐4-6 ☐7-11 ☐12+ ☐Permanent
		Date: ☐ Physical Health ☐ Mental Health ☐ Substance Use Disorder ☐ Other	☐1-3 ☐4-6 ☐7-11 ☐12+ ☐Permanent
		Date: ☐ Physical Health ☐ Mental Health ☐ Substance Use Disorder ☐ Other	☐1-3 ☐4-6 ☐7-11 ☐12+ ☐Permanent
		Date: ☐ Physical Health ☐ Mental Health ☐ Substance Use Disorder ☐ Other	☐1-3 ☐4-6 ☐7-11 ☐12+ ☐Permanent

IV. FUNCTIONAL LIMITATIONS (related to medical findings noted in Section III): *(check column that applies)*

a.) Physical Functioning	No. Evidence of Limitations	Moderately Limited	Very Limited	b.) Mental Functioning	No. Evidence of Limitations	Moderately Limited	Very Limited
Walking				Understands and remembers instructions			
Standing				Carries out instructions			
Sitting				Maintains attention/concentration			
Lifting, Carrying				Makes simple decisions			
Pushing, Pulling, Bending				Interacts appropriately with others			
Seeing, Hearing, Speaking				Maintains socially appropriate behavior without exhibiting behavior extremes			
Using Hands				Maintains basic standards of personal hygiene and grooming			
Stairs or other climbing				Appears able to function in a work setting at a consistent pace			
Other:				Other:			

V. TREATMENT HISTORY (list for medical, psychiatric, alcoholism and drug treatment for the past Two Years)

Name of Program/Provider	Type of Program/Provider i.e. Outpatient, Residential, Methadone (for addiction specify modality)	Length of Treatment (# of Months)

VI. CURRENT TREATMENT PROGRAM IDENTIFICATION (include medical, psychiatric, alcoholism and drug treatment as applicable.)

Program Name: _____

Address of Client's Treatment Site: _____

Mailing Address (If different from above): _____

Treatment Program Contact: _____ Title: _____

Telephone #: ( ) _____ Fax #: ( ) _____

VII. LIMITATIONS ON WORK ACTIVITIES

a. Taking into consideration physical, mental and addiction limitation(s), describe any working conditions, environments, or work activities which are contraindicated: _____

_____

b. Are these restrictions expected to last: ☐ 1-3 months ☐ 4-6 months ☐ 7-11 months ☐ 12+ months ☐ permanent

c. Do you recommend referral to rehabilitation, including but not limited to, a mental health or alcohol/substance abuse, or a physical rehabilitiation program? ☐ Yes ☐ No If yes, please specify: _____

VIII. SCREENING FOR POSSIBLE SSI REFERRAL

Based on the evidence available to you, does this individual have severe impairment(s) which has lasted, or is expected to last at least 12 months? IF YES, *please check* _____ Explain briefly: _____

_____ If substance abuse is also found, would such impairment be expected to continue if use of drugs and/or alcohol were to cease? ☐ Yes ☐ No

IX. PHYSICIAN INFORMATION

Physician's or Psychologist's Name *(please print)*: _____

Address: _____

Board eligible or certified specialty: _____ Tele.#: ( ) _____ Fax #: ( ) _____

Is this client a patient of the examining physician? ☐ Yes ☐ No If yes, for how long? _____

Date of Last Examination: _____

Signature of physician or psychologist: **X** _____ Date: _____

Please forward this completed form to Social Services Contact: _____

Telephone #: _____ Address: _____

Cover Letter to Accompany the Request for Medical Information

Date:
Re:
DOB:

Dear Health Care Provider:

The above named individual has been referred to you to help evaluate the extent to which he/she can participate in employment or job preparation services including job search, on-the-job training, job skills training, vocational rehabilitation or training, and educational activities including classroom instruction. Additionally, it is important to determine if participation in treatment or rehabilitation is warranted. We also need your assessment of the expected length of the impairment. If the individual has severe impairments that are expected to last at least 12 months or result in death, it may indicate that it would be most appropriate for the district to refer the individual to apply for federal disability benefits.

If the individual is capable of participating in employment or job preparation services in any capacity, we are also requesting information regarding the nature of any limitations so that appropriate accommodations are provided.

Please complete the enclosed medical form. If additional space or clarification is needed in any area, please attach the additional information. Treatment intensity should correspond to the severity of the condition. If, in your opinion, the individual is completely unable to participate in any activities and would not benefit from rehabilitation or treatment, please indicate that so the individual may be referred to the proper agencies and services.

I can be reached at _____if you require additional information.
Thank you for your time and consideration in this matter.

Sincerely,

_____
Worker Name

_____
Title