HEALTH COVERAGE FOR WORKERS WITH DISABILITIES (HCWD) MEDICAL INFORMATION RELEASE AUTHORIZATION

County of _____
Department of Social Services

Dr. _____
_____
_____
_____

Dear Doctor:

Your patient, _____, has authorized us to contact you to obtain information pertinent to his/her Medicaid eligibility (please see attached signed and dated authorization DMA-5028). Please take a moment to answer the following questions:

1. This patient was previously found to be disabled/blind as that term is defined by Social Security. Does he/she still have the underlying condition or conditions which made him/her disabled? Yes _____ No _____

2. If the answer to 1. is yes, what are those disabling conditions?

_____

_____

_____

_____

3. Is this patient still under treatment for the condition or conditions which made him/her disabled? Yes _____ No _____

4. If the answer to 3 is yes, is there a strong likelihood that this patient would again be disabled if he were to cease this treatment? Yes _____ No _____

_____
Please print your name

_____ _____
Signature Today's Date

Please return to the Department of Social Services in the envelope provided.