

MEDICAL – SOCIAL QUESTIONNAIRE

Michigan Department of Human Services

Case Name:

Case Number:

Date:

DHS Office:

Specialist / ID: /

Phone:

Fax:

Individual ID:

If you do not understand this, call a DHS office in your area.
 DHS employees are prohibited by law from providing legal advice.
 Si Ud. No entiende esto, llame a su oficina local del Department of Human Services.
 La ley prohíbe a los empleados de DHS proporcionar asesoría legal.
 إذا واجهت صعوبة في فهم هذا الطلب، فاتصل بمكتب DHS الموجود في منطقتك.
 يحرم القانون على موظفي DHS إعطاء النصيحة القانونية.

Department of Human Services (DHS) will not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, sex, sexual orientation, gender identity or expression, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.

ENTER ADDRESSEE NAME
 ENTER ADDRESSEE CARE OF
 ENTER ADDRESSEE PO BOX OR STREET
 ENTER ADDRESSEE CITY/STATE/ZIP

MEDICAL – SOCIAL QUESTIONNAIRE

Name of client about whom information is requested			Application/Review Date		Retroactive Date	
Program <input type="checkbox"/> MA Disability <input type="checkbox"/> MA Blind <input type="checkbox"/> Retroactive MA <input type="checkbox"/> SDA <input type="checkbox"/> PATH <input type="checkbox"/> Other _____			Case Status <input type="checkbox"/> New Application <input type="checkbox"/> Reopening <input type="checkbox"/> Reapplication <input type="checkbox"/> Review			
Date of Birth	Age	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number - -		Client Phone () -	
Client Address			City		State	Zip
Information Source (check all that apply) <input type="checkbox"/> Client <input type="checkbox"/> Relative <input type="checkbox"/> Other						
Living Arrangement (check all that apply) <input type="checkbox"/> Independent Living <input type="checkbox"/> Spouse <input type="checkbox"/> Rent <input type="checkbox"/> Lives alone <input type="checkbox"/> Parents <input type="checkbox"/> Room and board <input type="checkbox"/> Own home <input type="checkbox"/> With children <input type="checkbox"/> Homeless <input type="checkbox"/> Friends/relatives <input type="checkbox"/> Foster care <input type="checkbox"/> Other						

INSTRUCTIONS FOR THE CLIENT:

You **must** complete and sign this questionnaire if you are applying for financial or medical assistance or other program exemption due to a current disability. Attach additional sheets if you need more room to list your current medical condition or employment history. **If you need help completing this form, please contact your specialist.**

SECTION I – GENERAL INFORMATION

What are the illnesses, injuries, or conditions that limit your ability to work?	
Illness, injury, condition	When did it start?
How do your illnesses, injuries, or conditions limit your ability to work?	
What is your height:	What is your weight:
Can you speak and understand English? <input type="checkbox"/> Yes <input type="checkbox"/> No	Can you read and understand English? <input type="checkbox"/> Yes <input type="checkbox"/> No
If No, what language do you prefer:	If No, what language do you prefer:

SECTION II – CONTACT INFORMATION (Give the name of someone [other than your doctors] we can contact who knows about your medical conditions and can help you with your claim.)

Name	Relationship to you	Phone number
Mailing address (street/apartment or unit if applicable)	City/State/Province, Zip/Postal Code	Country (if not USA)
Can this person speak and understand English? <input type="checkbox"/> Yes <input type="checkbox"/> No	If No, what language is preferred?	

Case Name	Case Number	Specialist
-----------	-------------	------------

SECTION III – MEDICAL INFORMATION (Complete the following for each of your current doctors or other health care providers of the last 12 months, such as community mental health workers, therapists, clinics, case managers.)

If none in the last 12 months, complete with the last doctor seen and year.

A. Doctor/Health Care Provider	Date of Last Visit (Month/year)	Date of Next Visit	
Street Address	City	Zip Code	Telephone No.
Describe Illness			
B. Doctor/Health Care Provider	Date of Last Visit (Month/year)	Date of Next Visit	
Street Address	City	Zip Code	Telephone No.
Describe Illness			
C. Doctor/Health Care Provider	Date of Last Visit (Month/year)	Date of Next Visit	
Street Address	City	Zip Code	Telephone No.
Describe Illness			
D. Doctor/Health Care Provider	Date of Last Visit (Month/year)	Date of Next Visit	
Street Address	City	Zip Code	Telephone No.
Describe Illness			
E. Doctor/Health Care Provider	Date of Last Visit (Month/year)	Date of Next Visit	
Street Address	City	Zip Code	Telephone No.
Describe Illness			

LIST THE NAMES OF THE HOSPITAL OR OTHER MEDICAL FACILITY (Include Emergency Room [ER] and inpatient [IP] admission for the last 12 months)

Hospital/Facility Name	Dates of Admissions		Reason for Admission or Type of Treatment (Include emergency room [ER], or inpatient admissions to specialized clinics, mental health crisis facilities or substance abuse treatment centers)
	FROM (Mo/Year)	TO (Mo/Year)	
			ER or Admission? Reason?
			ER or Admission? Reason?
			ER or Admission? Reason?
			ER or Admission? Reason?

SECTION IV – MEDICAL TESTS AND MEDICATIONS – Check the box(es) for any medical tests that you have been given.

<input type="checkbox"/> Heart scan, Angiogram	When	Where
<input type="checkbox"/> X-Ray, MRI, CT scan	When	Where
Specify Type, Location	scanned	
<input type="checkbox"/> Breathing Tests	When	Where
<input type="checkbox"/> Psychological Testing	When	Where
<input type="checkbox"/> Other Tests	Type of test	Where/Where

Case Name	Case Number	Specialist
Prescribed Medications – List all medications prescribed by your doctor for your current medical condition(s):		
Non-Prescribed (over the counter) medications you currently take:		

SECTION V – EMPLOYMENT

Are you currently employed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not working, what is the last date you worked (month and year)?
Are you on Sick Leave <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, date you expect to return to work
Describe your job duties	

SECTION VI – PAST WORK HISTORY IF NO WORK IN 15 YEARS, CHECK THIS BOX AND GO TO SECTION VII.

CLIENT DID NOT WORK IN THE PAST 15 YEARS
(If client has not worked in the past 15 years, go to Section VII)

If client has worked, list all work performed in the past 15 years below and complete the **DHS-49WH** for each job listed.
(Attach additional pages, if needed.)

Job Titles	Type of Work	Dates of Employment		Hours per week/pay per hour
		FROM (Mo/Year)	TO (Mo/Year)	
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

SECTION VII – EDUCATION

Highest grade completed (Month, Year)	If less than 12 th grade, reason for leaving	GED completed? <input type="checkbox"/> Yes <input type="checkbox"/> No
Special education? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, name and address of the last school attended:	
Currently attending school or a Michigan rehabilitation program? <input type="checkbox"/> Yes <input type="checkbox"/> Not Attending	If yes, name and address below	
List any other employment or educational skills, rehabilitation programs, certificates, licenses, etc.		

SECTION VIII – SIGNATURE

Signature Of Person Completing Form	Relationship To Client If Not Completed By Client	Date Completed
-------------------------------------	---	----------------

Case Name	Case Number	Specialist
-----------	-------------	------------

FOR DHS SPECIALIST USE ONLY

SECTION IX – OTHER CLAIM INFORMATION

SSI/RSDI Status

<input type="checkbox"/> Not receiving (include date) <input type="checkbox"/> Previously received	<input type="checkbox"/> Pending/level (include date) From _____ To _____	<input type="checkbox"/> Receiving (include date) Reason stopped _____
---	--	---

Additional Claims/Filings

Has client filed for Workers' Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, current status:
Has client filed for a military pension/disability? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, current status:
Is there a pending lawsuit regarding client's disability/impairment? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, current status:

Current Income (check all that apply)

<input type="checkbox"/> SFA	<input type="checkbox"/> Workers' Compensation	<input type="checkbox"/> Disability benefits	<input type="checkbox"/> SDA
<input type="checkbox"/> UCB	<input type="checkbox"/> Veteran's benefits	<input type="checkbox"/> Other _____	

SECTION X – WORKER OBSERVATIONS

Indicate if difficulty was (or has been) observed for any of the following (explain below):

<input type="checkbox"/> Allergies	<input type="checkbox"/> Hearing	<input type="checkbox"/> Signs of fatigue	<input type="checkbox"/> Using hand difficulty
<input type="checkbox"/> Answering	<input type="checkbox"/> Hostile demeanor	<input type="checkbox"/> Signs of pain or distress	<input type="checkbox"/> Right hand difficulty
<input type="checkbox"/> Appearance	<input type="checkbox"/> Memory	<input type="checkbox"/> Sitting	<input type="checkbox"/> Left hand difficulty
<input type="checkbox"/> Breathing	<input type="checkbox"/> Reading	<input type="checkbox"/> Skin condition	<input type="checkbox"/> Walking
<input type="checkbox"/> Drug / Alcohol abus	<input type="checkbox"/> Seeing	<input type="checkbox"/> Standing	<input type="checkbox"/> Withdrawn
<input type="checkbox"/> Eye contact	<input type="checkbox"/> Seizures	<input type="checkbox"/> Understanding	<input type="checkbox"/> Writing

Signature of worker	Title	Date Completed
---------------------	-------	----------------

AUTHORITY: P.A. 288 of 1988, P.A. 368 of 1996, 42 CFR and 45 CFR RESPONSE: Mandatory PENALTY: Inability to determine eligibility for assistance	"In accordance with Federal law and U.S. Department of Agriculture (USDA) policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, religion, political beliefs, or disability. To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, S.W., Washington D.C. 20250-9410 or call (800) 795-3272 (voice) or (202) 720-6382 (TTY). USDA is an equal opportunity provider and employer."
--	---