NEW YORK STATE DEPARTMENT OF HEALTH
Office of Health Insurance Programs

MEDICAL REPORT FOR MBI-WPD MEDICAL IMPROVEMENT GROUP CONTINUING DISABILITY REVIEW

AGENCY NAME AND ADDRESS	PATIENT'S NAME: (Last) (First) (Middle)
______________________________	______________________________
______________________________	PATIENT'S DATE OF BIRTH: ______________________________
______________________________	PATIENT'S CASE NUMBER: ______________________________
______________________________	
______________________________	
Agency telephone number ______________________________	PATIENT'S CIN: ______________________________

Dear Medical Provider,

Medical eligibility for the Medicaid Buy-In program for Working People with Disabilities (MBI-WPD) Medical Improvement Group is being re-determined for the individual named above. The information requested on this form will be used to determine if the individual continues to meet the medical eligibility requirements for this program. Your promptness returning this form will help ensure a timely decision on the individual's eligibility.

Enclosed with this document is a medical release signed by the patient or his/her personal representative.

Thank you for your cooperation.

Instructions for completion

Please complete parts A through D of this form by following the instructions for each section. Please sign, date and return this form to the agency noted above.

A. Current diagnosis(es)/impairments(s):
Please include all known diagnoses for this patient, regardless of your area of specialty.

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Continue next page

Patient Name:____ Date of Birth: ___________

B. The individual requires the following care, services or supports, the loss of which could result in the inability to continue to function at his/her current level.
(Please check all boxes that apply and supply requested information.)

☐ On-going, impairment-related monitoring: (If you check this box, please check all of the below boxes that apply and supply the information requested on the lines provided.

- ☐ Follow-up visits: (frequency: __________; date of last visit:___________)
- ☐ Medical Testing: (e.g., lab work, medical imaging, etc.)
- ☐ Psychotherapy/Counseling: (frequency: __________; date of last visit: _______)
- ☐ Other: (specify)____
  ____

☐ Medication management: In the space below, please list names of medications or attach a list.

☐ Medical equipment or supplies necessary to accommodate impairment(s): (e.g., prosthesis, vision and sensory aids, telecommunication devices, special tools designed to accommodate an impairment) In the space below, please document equipment and/or supplies.

☐ Medical services related to the control of the disabling impairment(s): (e.g., physical, occupational, and speech/language therapies) Please document service(s).

☐ Impairment-related support services: (e.g., assistant care services, supportive employment, job coach, supportive living programs) In the space below, please document service(s).

THIS IS THE END OF PART B. If you checked at least one box in part B, please stop, sign and date the form, and return it to the agency noted at the top of page 1. Completion of the attached LDSS-486T form is not necessary. If you did not check at least one box in this section, please complete parts C and D.

Continue next page

C. If the individual does not require any of the care, services or supports listed in part B to maintain his/her current level of function, check the box below and go on to part D.

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Comments, if applicable:

D. If the individual's impairment(s) has/have worsened in the past 12 months, check the box below. If you check this box, please enclose all available medical evidence, such as progress notes and testing reports for the past 12 months. Additionally, please complete the attached LDSS-486T form. If you did not check this box, please disregard the LDSS 486T form and return only this form to the agency listed on the top of page 1 of this form.

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Thank you for your cooperation.

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(signature) **(title)**

______________________________ ______________________________

(print name) **(date)**