

DISABILITY REVIEW TEAM CERTIFICATE

NEW YORK STATE

DEPARTMENT OF HEALTH

1. CASE NUMBER	2. CASE NAME (LAST, FIRST, MIDDLE)	3. EXPIRATION DATE
4. CLIENT I.D. # (CIN)	5. NAME OF AGENCY	
6. DATE OF THIS REVIEW	7. DIAGNOSIS	
8. REVIEW TEAM'S DETERMINATION (Written explanation must be completed in #10) <input type="checkbox"/> APPROVED <input type="checkbox"/> GROUP I <input type="checkbox"/> GROUP II <input type="checkbox"/> DISAPPROVED <input type="checkbox"/> NO ACTION DATA INADEQUATE ON <input type="checkbox"/> MEDICAL <input type="checkbox"/> SOCIAL		9. EFFECTIVE DATE OF DISABILITY
10. REQUESTS FOR ADDITIONAL DATA OR REASONS FOR DETERMINATION		
11. SIGNATURE OF REVIEWING PHYSICIAN	12. SIGNATURE OF REVIEWING CASE REVIEWER	
X	X	

INSTRUCTIONS

Disability Review Team Certificate

1. Agency Instructions

Items 1 (Case Number), 2 (Case Name), 4 (Client I.D. #) and 5 (Name of Agency) are to be completed by the appropriate local district worker.

2. Review Team Instructions

Item 3 (Expiration Date).

Enter the expiration date of the case has been classified as Group II. The initial time interval shall be no less than one year from the effective date of the disability (indicated in Item 9). However, the Disability Review Team may request that additional data or a progress report be submitted at any time during such twelve-month period. Group I cases do not have to be submitted for further eligibility determination unless the factors of medical or social eligibility change.

Item 6 (Date of Review).

Enter the date the Review Team made the present determination.

Item 7 (Diagnosis).

Enter the primary and any other diagnoses being considered by the Disability Review Team.

Item 8 (Review Team's Determination).

Indicate whether a case is "Approved", "Disapproved", or "No Action". If approved, indicate whether the case is Group I or Group II. If the case is a "No Action", indicate whether the medical and/or social data is inadequate.

Item 9 (Effective Date of Disability).

Enter the effective date of medical disability established by the Review Team. (See Department Regulations 360.40 as reflected in the MA Disability Manual for instructions.)

Item 10 (Request for Additional Data or Reasons for Determination).

This section must be completed in all cases to demonstrate the reason(s) for the determination. Regulatory citations such as, specific listing of impairment(s) evaluated, the client's residual functional capacity and applicable medical/vocational considerations or failure to meet durational requirement must be detailed in this section to indicate a rationale for the Review Team's decision. If any medical and/or social evidence is lacking in the record in order to make a determination, it should be indicated. Further, if specific documentation is needed for recertification for Group II cases, it should be noted.

Item 11 (Signature of Reviewing Physician) and Item 12 (Signature of Reviewing Social Worker).

The reviewing physician and case reviewer sign names in full.