CITY OF Salem AT YOUR SERVICE

# Disabled Dependent Certification form

For Continuation of Health Insurance
For a Disabled Child over Age 26

## SECTION 1: TO BE COMPLETED BY THE SUBSCRIBER

| Subscriber's Name: | Subscriber's ID Number: |
|---|---|
| Subscriber's Address: | |

| Name of Dependent Child: | Child's Birth Date: | Child's Age When Disability Began: |
|---|---|---|
| Child's Relationship to You:<br>☐ Natural Child ☐ Step-Child ☐ Partner's Child<br>☐ Adopted Child ☐ Foster Child ☐ Other: | Child's Sex:<br>☐ Male<br>☐ Female | Child's Marital Status:<br>☐ Single<br>☐ Married |

Is the child primarily dependent upon you for support? ☐ Yes ☐ No
If "yes," what part of support do you contribute?

Was the child ever employed? ☐ Yes ☐ No Is the child employed now? ☐ Yes ☐ No
If either answer is "yes," list employer's name, address, and dates of employment:

Monthly wages/earnings:

Is the child covered under any other health insurance plan? ☐ Yes ☐ No
If "yes," provide the name of the insurance company and group or policy number.

I hereby certify that the above information is correct to the best of my knowledge and authorize release of any information requested with respect to this certification. I understand that to qualify for continued coverage on the City of Salem Health Plan beyond age 26, my dependent child must be totally disabled, incapable of self-sustaining employment by reason of mental or physical disability, primarily dependent upon myself or my spouse/domestic partner for support and maintenance, and unmarried. I understand that recertification of disability may be required periodically.

| Subscriber Signature: | Date: |
|---|---|

## SECTION 2: DEPENDENT CHILD AUTHORIZATION

*The dependent, or the person legally authorized to act on the dependent's behalf, is to complete the information requested in this section before giving this form to the health care provider for completion.*

I hereby authorize my attending physician (name): _____ to furnish and disclose all facts concerning my disability that are within their knowledge and to allow inspection, and provide copies, of any medical records concerning my disability that are under their control. This authorization shall be valid for a period of one year from the date of my signature. I agree that a photocopy of this authorization shall be as valid as the original. I understand that if I do not sign this authorization, or if I revoke or modify it, the City of Salem Health Plan may not be able to determine my eligibility as a disabled dependent child and that my request may be denied. I also understand that the City of Salem Health Plan will keep confidential the information that is provided pursuant to this authorization and that it will be used solely to determine and act upon my request for continuation of health insurance coverage beyond age 26.

| Signature of Dependent Child: | Date Signed: |
|---|---|
| Signature of Person Legally Authorized to Act on Dependent's Behalf: | Relationship to Dependent: |

CITY OF Salem AT YOUR SERVICE

# Disabled Dependent Certification

For Continuation of Health Insurance
For a Disabled Child over Age 26

Dear Physician:
This form will assist the City of Salem Health Plan in processing the patient's claim for health insurance coverage as a disabled dependent under his or her parent's or guardian's health plan. By providing the medical information requested promptly and legibly, you will help the patient expedite the claims process. **Please send the completed form to:**

City of Salem, Human Resources/Benefits Division, 555 Liberty Street SE, Room 225, Salem, OR 97301; or
Confidential Fax: 503-588-6170

## SECTION 3 – MEDICAL REPORT TO BE COMPLETED BY THE ATTENDING PHYSICIAN

I attended patient for the current disabling medical condition from _____ to _____ (dates).

I last examined the patient on _____ (date).

| Diagnosis: | Date of Onset: |
|---|---|
| ICD-9 Code(s): | DSM IV Code(s), if any: |

Statement of symptoms, clinical findings, and treatment:

**Functional Assessment of Activities of Daily Living (ADLs):** Indicate the patient's degree of physical and mental disability in the following ADLs using a scale of 1 to 10. One (1) indicates the ADL is not affected by the disability. A ten (10) indicates complete disability in the ADL. These functional disabilities limit the patient's capacity for self-support.

| **Mobility Skills** | **Self-Care Skills** | **Sensory Skills** | **Cognitive Skills** |
|---|---|---|---|
| ___ walking ___ standing<br>___ sitting ___ bending<br>___ lifting | ___ feeding ___ dressing<br>___ bathing ___ toileting | ___ hearing ___ touch<br>___ seeing ___ speech | ___ judgment ___ memory<br>___ planning/follow through<br>___ thinking/processing information |

**Psychological/Psychiatric Assessment:** List the specific psychological/psychiatric symptoms and behaviors (if any) that affect the patient's ADLs and limit his or her capacity to be self-supporting.

Based on your examination, does this patient currently have a physically or mentally disabling injury, illness, or condition?

☐ No, the patient does not have a physically or mentally disabling injury, illness, or condition.
☐ Yes. (Please answer the next question.)

In your medical or psychiatric opinion, please select **A**, **B**, or **C**:

☐ **A.** The patient's current disability DOES NOT render him or her incapable of self-support.

☐ **B.** The patient's current disability DOES render him or her incapable of self-support, but the disability should resolve or improve sufficiently for the patient to be capable of self-support by (projected date) _____.
*Please make some estimate, including month and year, of when the condition is likely to improve or resolve.*

☐ **C.** The patient's current disability is of permanent or extended duration and, consequently, the patient is not and will not be capable of self-support within the foreseeable future (e.g., more than five years).

I certify that, based on my examination of the patient, the above statements truly describe the patient's disability and his or her capability of self-support, and that I am a _____(specialty) licensed to practice in the state of _____.

| Physician's name: | Physician's address: |
|---|---|
| Physician's signature: | |
| Date: | Telephone number: |