An Independent Licensee of the Blue Cross and Blue Shield Association

DISABLED DEPENDENT CERTIFICATION

TO BE COMPLETED BY EMPLOYEE/PENSIONER

1. Name of Employee/Pensioner/Surviving Spouse (print - last, first & middle initial) | 2. Group Number | 3. Identification Number

4. Employee/Pensioner/Surviving Spouse Address (number, street, city, state, & zip code)

5. Disabled Dependent's Name | Disabled Dependent's Birthdate Month Day Year | Disabled Dependent's Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Disabled Dependent's Relationship to Employee/Pensioner | Disabled Dependent's Sex ☐ Male ☐ Female | Disabled Dependent's Age When Disability Occurred

6. Is dependent permanently residing in your household? ☐ Yes ☐ No If "No", please explain: ____________

7. Is the person dependent upon you for financial support? ☐ Yes ☐ No **If "Yes", indicate percentage of financial support you contribute:** ☐ **25%** ☐ **50%** ☐ **75%** ☐ **100%** ____ %

   If "No", please explain: ____________

8. Is dependent listed as a dependent in your last Federal Income Tax Return? ☐ Yes ☐ No If "No", please explain: ____________

9. Was the dependent certified as a student dependent at the time of the disability? ☐ Yes ☐ No

10. Current student status: ☐ Full time ☐ Part time ☐ Not Applicable

11. Was dependent ever employed? ☐ Yes ☐ No

12. Is dependent employed now? ☐ Yes ☐ No

13. If answer to question 11 or 12 is "Yes", give name(s) and address(es) of employer(s) and date(s) employed. ____________

14. Was dependent covered under your (former) employer's program prior to age of deletion? ☐ Yes ☐ No

15. Disabled dependent's Social Security Number ____________

16. Is dependent now covered under Medicare or any other hospital-medical coverage? ☐ Yes ☐ No If "Yes", please complete the following:

    Medicare Health Insurance Claim Number ____________ Hospital Insurance (PART A) Effective Date ____________ Medical Insurance (PART B) Effective Date ____________

    If covered by other insurance, please print name of the employer, the insurance company name, and your certificate or agreement number on the reverse side hereof.

    NOTE: If you have not already done so, it may be to your financial advantage to contact Social Security and apply for Social Security Disability payments and/or Medicare Health Insurance or Supplemental Security Income (SSI) and/or Medicaid on behalf of your disabled dependent.

    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.

Signature of Employee/Pensioner or Surviving Spouse | Date Signed | ( ) Home Phone # | ( ) Work Phone #

17. OTHER HOSPITAL/MEDICAL INSURANCE

    Policyholder name ____________ Employer name & phone number ____________

    Insurance Carrier name & phone number ____________

    Policy and/or Social Security Number ____________ Effective date of coverage ____________

TO BE COMPLETED BY EMPLOYER

1. Was the disabled dependent listed on the employee/pensioner/surviving spouse's coverage before the above named disabled dependent attained the age of deletion? ☐ Yes ☐ No
2. Are you an ASO account? ☐ Yes ☐ No
3. Address of Employer ____________

Signature of Company Representative at Work Location | Title | ( ) Phone # | Date

TO BE COMPLETED BY ATTENDING PHYSICIAN

DIRECTIONS TO ATTENDING PHYSICIAN:

- **Please complete all areas of this form and then proceed to the Level of Impairment chart and circle one appropriate indicator per category.**
- **If the patient has a psychiatric related diagnosis, please complete the Brief Psychiatric Rating Scale and Global Assessment Scale.**
- **Your prompt completion of this form will expedite the disability application process.**
- **Any fee for completion of this form and other forms for dependent disability determination is the responsibility of the employee.**

Is dependent now incapable of self-support because of disability? ❑ Yes ❑ No

Has such disability existed continuously since before dependent attained age 19? ❑ Yes ❑ No

When did present illness begin or injury occur? Date: ____________________

Does the patient have a previous history of this illness? ❑ Yes ❑ No

If "Yes", please explain ____________________

____

____

____

Date disability commenced: ____________________

Subjective symptoms: ____________________

____

Objective findings (please provide dates of surgery, x-rays, or other tests): ____________________

____

____

____

____

Diagnosis description or medical history and medications (please give as much detail as possible): ____________________

____

____

____

____

____

____

____

Date of last office visit: ____________________ Frequency of visits: ____________________

PROGRESS: ❑ Recovered ❑ Improved ❑ Unimproved ❑ Regressed

Prognosis for employment: ____________________

NAME OF PHYSICIAN (print or type)	TELEPHONE NUMBER	DEGREE

ADDRESS OF PHYSICIAN (print or type)

PHYSICIAN'S SIGNATURE (print or type)	DATE

ADDITIONAL COMMENTS: ____________________

____

____

____

Global Assessment Scale (GAS)

Robert L. Spitzer, M.D., Miriam Gibbon, M.S.W., Jean Endicott, Ph.D.

Rate the subject's lowest level of functioning in the last week by selecting the lowest range which describes his functioning on a hypothetical continuum of mental health illness. For example, a subject whose "behavior is considerably influenced by delusions" (range 21-30) should be given a rating in that range even though he has "major impairment in several areas" (range 31-40). Use intermediary levels when appropriate (e.g., 35, 58, 62). Rate actual functioning independent of whether or not subject is receiving and may be helped by medication or some other form of treatment.

Name of Patient: ______________ ID No. ______________ Group Code: ______________

Admission Date: ______________ Date of Rating: ______________ Rater: ______________

G A S Rating: ______________ PHYSICIAN'S SIGNATURE: ______________

100–91 Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his/her warmth and integrity. No Symptoms.

90–81 Good functioning in all areas, many interests, socially effective, generally satisfied with life. There may or may not be transient symptoms and "everyday" worries that only occasionally get out of hand.

80–71 No more than slight impairment in functioning, varying degrees of "everyday" worries and problems that sometimes get out of hand. Minimal symptoms may or may not be present.

70–61 Some mild symptoms (e.g., depressive mood and mild insomnia) OR some difficulty in several areas of functioning, but generally functioning pretty well, has some meaningful interpersonal relationships and most untrained people would not consider him/her "sick"

60–51 Moderate symptoms OR generally functioning with some difficulty (e.g., few friends and flat affect, depressed mood and pathological self-doubt, euphoric mood and pressure of speech, moderately severe antisocial behavior).

50–41 Any serious symptomatology or impairment in functioning that most clinicians would think obviously requires treatment or attention (e.g., suicidal preoccupation or gesture, severe obsessional rituals, frequent anxiety attacks, serious antisocial behavior, compulsive drinking, mild but definite manic syndrome).

40–31 Major impairment in several areas such as work, family relations, judgement, thinking or mood (e.g., depressed woman avoids friends, neglects family, unable to do housework), OR some impairment in reality testing or communication (e.g., speech is at times obscure, illogical or irrelevant), OR single suicide attempt.

30–21 Unable to function in almost all areas (e.g., stays in bed all day) OR behavior is considerably influenced by either delusions or hallucinations OR serious impairment in communication (e.g., sometimes incoherent or unresponsive) or judgment (e.g., acts grossly inappropriately).

20–11 Needs some supervision to prevent hurting self or others, or to maintain minimal personal hygiene (e.g., repeated suicide attempts, frequently violent, manic excitement, smears feces) OR gross impairment in communication (e.g., largely incoherent or mute).

10–1 Needs consistent supervision for several days to prevent hurting self or others (e.g., requires an intensive care unit with special observation by staff), makes no attempt to maintain minimal personal hygiene, or serious suicide act with clear intent and expectation of death.

LEVEL OF IMPAIRMENT SCALE

NOTE: Any fee for the completion of this and other forms for dependent disability is the responsibility of the employee.

*	requires minimal help < 25% of the time.
* *	requires moderate help 25 - 50% of the time.
* * *	requires major help 50 - 75% of the time.

Dependent meets eligibility requirements of the groups as verified by completion of the Disabled Dependent Certification form. ❑ **YES** ❑ **NO**

If NO, refer: ______________________________

GUIDELINES

A. Medical Diagnosis: ______________________________

B. Level of Impairment: ______________

SELECT 1 INDICATOR PER INDICATOR	1	2	3	4	5
motor	**self sufficient**	**needs minimal help** *	**needs moderate help** **	**needs major help** ***	**dependent**
functional (ADLs)	**self sufficient**	**needs minimal help** *	**needs regular help** **	**needs major help** ***	**dependent**
mental capacity	**no deficit**	**slight deficit**	**moderate deficit**	**mod/severe deficit**	**severe deficit**
judgement	**no deficit**	**slight deficit**	**moderate deficit**	**mod/severe deficit**	**severe deficit**
rehab potential	**excellent**	**good**	**good for partial restoration**	**condition static**	**condition will worsen**
employment	**excellent**	**good**	**good for part-time employment**	**good for low level employment**	**poor**
Total	________	________	________	________	________

Sum 1+2+3+4+5 ______________

C. Mental Nervous Diagnosis: ______________________________

D. Level of Impairment: ______________

	1	2	3	4	5
intelligence	**normal or better**	**mildly retarded**	**moderately retarded**	**severely retarded**	**profoundly retarded**
perception	**no deficit**	**slight deficit**	**moderate deficit**	**mod/severe deficit**	**severe deficit**
thinking	**no deficit**	**slight deficit**	**moderate deficit**	**mod/severe deficit**	**severe deficit**
judgement	**no deficit**	**slight deficit**	**moderate deficit**	**mod/severe deficit**	**severe deficit**
affect	**normal**	**slight problem**	**moderate problem**	**mod/severe problem**	**severe problem**
behavior	**normal**	**slight problem**	**moderate problem**	**mod/severe problem**	**severe problem**
functional (ADLs)	**self sufficient**	**needs minimal help**	**needs regular help**	**needs major help**	**dependent**
intelligence potential	**excellent**	**good**	**good for partial**	**condition static**	**condition will worsen**
Total	________	________	________	________	________

Sum 1+2+3+4+5 ______________

Patient Name: ______________________ Agreement Number: ______________________

Physician Name: ______________________ Signature: ______________________

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
PUBLIC HEALTH SERVICE
Alcohol Drug Abuse and Mental Health Administration
NIMH-PRB Collaborative Study of Maintenance
Drug Therapy in Affective Illness

BRIEF PSYCHIATRIC RATING SCALE

Overall and Gorham

FORM NO.	UNIT NO.	SUBJECT GROUP	STUDY NO.	RATER NO.	PERIOD NO.

FACILITY	SUBJECT'S ID NO.	INITIALS

RATER	DATE

Write in the appropriate number for each item, using the following key:

Not Present	Very Mild	Mild	Moderate	Moderately Severe	Severe	Extremely Severe
1	2	3	4	5	6	7

1. SOMATIC CONCERN (13) ______
Degree of concern over present bodily health. Rate the degree to which physical health is perceived as a problem by the patient, whether complaints have a realistic basis or not.

2. ANXIETY (14) ______
Worry, fear, or over-concern for present or future. Rate solely on the basis of verbal report of patient's own subjective experiences. Do not infer anxiety from physical signs or from neurotic defense mechanisms.

3. EMOTIONAL WITHDRAWAL (15) ______
Deficiency in relating to the interviewer and to the interviewer situation. Rate only the degree to which the patient gives the impression of failing to be in emotional contact with other people in the interview situation.

4. CONCEPTIONAL DISORGANIZATION (16) ______
Degree to which the thought processes are confused, disconnected or disorganized. Rate on the basis of integration of the verbal products of the patient; do not rate on the basis of patient's subjective impression of his own level of functioning.

5. GUILT FEELINGS (17) ______
Over-concern or remorse for past behavior. Rate on the basis of the patient's subjective experiences of guilt as evidenced by verbal report with appropriate affect; do not infer guilt feelings from depression, anxiety, or neurotic defenses.

6. TENSION (18) ______
Physical and motor manifestations of tension "nervousness", and heightened activation level. Tension should be rated solely on the basis of physical signs and motor behavior and not on the basis of subjective experiences of tension reported by the patient.

7. MANNERISMS AND POSTURING (19) ______
Unusual and unnatural motor behavior, the type of motor behavior which causes certain mental patients to stand out in a crowd of normal people. Rate only abnormality of movements; do not rate simple heightened motor activity here.

8. GRANDIOSITY (20) ______
Exaggerated self-opinion, conviction of unusual ability or powers. Rate only on the basis of patient's statements about himself or self-in-relation-to-others, not on the basis of his demeanor in the interview situation.

9. DEPRESSIVE MOOD (21) ______
Despondency in mood, sadness. Rate only degree of despondency; do not rate on the basis of inferences concerning depression based upon general retardation and somatic complaints.

10. HOSTILITY (22) ______
Animosity, contempt, belligerence, disdain for other people outside the interview situation. Rate solely on the basis of the verbal report of feelings and actions of the patient toward others; do not infer hostility from neurotic defenses, anxiety nor somatic complaints. (Rate attitude toward interviewer under "uncooperativeness").

11. SUSPICIOUSNESS (23) ______
Belief (delusional or otherwise) that others have now, or have had in the past, malicious or discriminatory intent toward the patient. On the basis of verbal report, rate only those suspicions which are currently held whether they concern past or present circumstances.

12. HALLUCINATORY BEHAVIOR (24) ______
Perceptions without normal external stimulus correspondence. Rate only those experiences which are reported to have occurred within the last week and which are described as distinctly different from the thought and imagery processes or normal people.

13. MOTOR RETARDATION (25) ______
Reduction in energy level evidenced in slowed movements. Rate on the basis of observed behavior of the patient only; do not rate on the basis of patient's subjective impression of own energy level.

14. UNCOOPERATIVENESS (26) ______
Evidence of resistance, unfriendliness, resentment, and lack of readiness to cooperate with the interviewer. Rate only on the basis of the patient's attitude and responses to the interviewer and the interview situation; do not rate on the basis of reported resentment or uncooperativeness outside the interview situation.

15. UNUSUAL THOUGHT CONTENT (27) ______
Unusual, odd, strange, or bizarre thought content. Rate here the degree or unusualness, not the degree of disorganization of the thought processes.

16. BLUNTED AFFECT (28) ______
Reduced emotional tone, apparent lack of normal feeling or involvement.

17. EXCITEMENT (29) ______
Heightened emotional tone, agitation, increased reactivity.

18. DISORIENTATION (30) ______
Confusion or lack of proper association for person, place or time.

19. ELEVATED MOOD (31) ______
Happy, laughing, joking optimistic, with exaggerated sense of well-being.

Patient Name: ______________________ **Agreement Number:** ______________

Physician's Signature: ______________________