BHSF Form MS
Revised 6/27/14

Social Information Interview Form

A. Instructions

This form is used to help Medicaid determine if you have a disability. If you already have a disability decision from the Social Security Administration (SSA), you do not need to fill this out. Please print clearly and answer all questions.

B. Identifying Information

Name		Today's Date	
Social Security Number	Date of Birth	Age	Sex ☐ Male ☐ Female

C. Education

Highest Grade Completed	Year you last attended school or a training program	
Were you in special education classes? ☐ Yes ☐ No	When?	Where?
Did you go to a Vocational school? ☐ Yes ☐ No	What type?	
Have you had other training? ☐ Yes ☐ No	What type?	

D. Work History

Tell us about the jobs you've had over the past 15 years.

1	Where did you work?	When did you work there? From To	How many hours per week?
Reason for Leaving		Do you believe you could perform this job now? ☐ Yes ☐ No	
Describe your major duties at this job			
2	Where did you work?	When did you work there? From To	How many hours per week?
Reason for Leaving		Do you believe you could perform this job now? ☐ Yes ☐ No	
Describe your major duties at this job			
3	Where did you work?	When did you work there? From To	How many hours per week?
Reason for Leaving		Do you believe you could perform this job now? ☐ Yes ☐ No	
Describe your major duties at this job			
4	Where did you work?	When did you work there? From To	How many hours per week?
Reason for Leaving		Do you believe you could perform this job now? ☐ Yes ☐ No	
Describe your major duties at this job			

If you need more space, use a separate piece of paper and attach it.

E. Abilities

1. What is your disability? _____

   _____

2. When did your disability start? _____

3. Check each box if your illness, injury, or condition affects your ability to do the activity.

☐ Understand Directions	☐ Complete Tasks	☐ Stand for 30 Minutes
☐ Handle Change in Routine	☐ Get Along with Others	☐ Sit for an Hour
☐ Get Along with Authority	☐ Handle Stress	☐ Bend or Stoop Down
☐ Follow Spoken Instructions	☐ Concentrate	☐ Walk a Block
☐ Follow Written Directions	☐ See (w/glasses, if needed)	☐ Other, please explain:
☐ Remember Routine Things	☐ Hear (w/aid, if needed)	_____

4. List other ways your condition affects your ability to work or do activities.

   _____

5. Do you have problems getting along with family, friends, or neighbors? ☐ Yes ☐ No

   If yes, explain. _____

6. Do you use any assistive devices (Examples: cane, wheelchair, or walker)?
   ☐ Yes – **If yes**, answer the next questions. ☐ No – **If no**, skip to Section F.

   a. What kind of assistive device? ☐ Cane ☐ Wheelchair or scooter ☐ Walker ☐ Other: _____

   b. How often do you use the assistive device? ☐ Seldom ☐ Frequently ☐ Always

   c. Was the assistive device prescribed? ☐ Yes ☐ No — **If Yes,** who prescribed it? _____

F. Activities

1. Check each box for activities you can do by yourself.

☐ Yard Work	☐ Light Housekeeping	☐ Cook and Prepare Meal
☐ Drive	☐ Pay Bills	☐ Shop
☐ Child Care	☐ Care for Pets/Animals	☐ Daily Hygiene (bathe, etc.)
☐ Take Medication	☐ Attend Church	☐ Talk on Phone
☐ Use Computer	☐ Social Activities	☐ Care for Elderly/Others
☐ Keep a Checkbook	☐ Make Purchases	☐ Count Change

2. For activities you need help with, who helps you and how do they help you?

   _____

3. When going out, how do you travel?

   ☐ Walk ☐ Drive a Car ☐ Ride in a Car ☐ Ride a bicycle ☐ Take public transportation/bus ☐ Other

4. List places where you regularly go.

   _____

5. What are your hobbies and interests? (Examples: read, watch TV, play sports, exercise, volunteer, sew)

   _____

   _____

   _____

G. Healthcare Information

List all doctors, hospitals, and clinics where you have received treatment. Send all medical records from the last 24 months pertaining to your disability. If you have a mental disability, send all medical records. If we have to request your medical records from your providers, we will need you to sign a form for each provider.

Provider (doctor, hospital, or clinic name)	Provider Address and Phone Number	Dates Treated		Reason for Treatment
		From	To	
		From	To	
		From	To	
		From	To	
		From	To	
		From	To	
		From	To	
		From	To	
		From	To	
		From	To	

If you need more space, use a separate piece of paper and attach it.

H. Medications

Tell us about all medications that you currently take.

Name of medication	Dosage	How often do you take it?	Who prescribed this medication?	Date of last visit with this provider

If you need more space, use a separate piece of paper and attach it.

I. Other Benefits

We need to know about benefits that you get or benefits for which you might qualify. Check all boxes that apply.

Benefit Type	Tell us if you get this benefit, if you've applied, or if you might qualify.
Social Security Disability (SSDI) You might qualify for this if you or a spouse has worked and paid into Social Security.	☐ I already get this benefit. ☐ I might qualify, but I have not applied. ☐ I applied. The status of my benefit is: ☐ Pending ☐ Denied or terminated
Supplemental Security Income (SSI) You might qualify for this if you have not paid into Social Security and you have very low income.	☐ I already get this benefit. ☐ I might qualify, but I have not applied. ☐ I applied. The status of my benefit is: ☐ Pending ☐ Denied or terminated
Retirement or Disability Retirement You might qualify for this if you've paid into a retirement plan through an employer.	☐ I already get this benefit. ☐ I might qualify, but I have not applied. ☐ I applied. The status of my benefit is: ☐ Pending ☐ Denied or terminated
Disability Insurance Plan You might qualify for this if you've paid for an insurance plan that offers disability coverage (like Aflac).	☐ I already get this benefit. ☐ I might qualify, but I have not applied. ☐ I applied. The status of my benefit is: ☐ Pending ☐ Denied or terminated
Veterans Benefits You might qualify for this if you or a spouse is a Veteran.	☐ I already get this benefit. ☐ I might qualify, but I have not applied. ☐ I applied. The status of my benefit is: ☐ Pending ☐ Denied or terminated
Vocational Rehabilitation (VR) This program helps people with disabilities get training so they can work.	☐ I already get this benefit. ☐ I might qualify, but I have not applied. ☐ I applied. The status of my benefit is: ☐ Pending ☐ Denied or terminated
Other (please explain):	☐ I already get this benefit. ☐ I might qualify, but I have not applied. ☐ I applied. The status of my benefit is: ☐ Pending ☐ Denied or terminated

J. Other Information

Tell us any other information you'd like us to know about your condition.

Who filled out this form? _____ Relation to applicant _____

K. Agency Use Only

Was a face to face interview conducted? ☐ Yes ☐ No

If yes, date of interview: _____ **If no**, why wasn't an interview conducted? _____

Provide additional information such as appearance and manifestations of the condition.

Agency Representative _____ Agency Name _____