Application For Intellectual Disability

ND

Member Information

Unique Member Identifier

Dependent's Name	Social Security Number

Medicare ID Card Number

Hospital Part A Effective Date	Medical Part B Effective Date	Prescription Drug Part D Effective Date
☐☐01☐☐	☐☐01☐☐	☐☐01☐☐

Subscriber's Statement – To Be Completed By Subscriber

1. Does dependent reside at the home of the subscriber?

   ☐ Yes ☐ No – If no, why? (ie. divorce decree, group home, residential facility)

   Address of dependent:
   Address City State Zip Code

2. Is the dependent claimed on the subscriber's federal tax income return? ☐ Yes ☐ No

3. Is the dependent unmarried? ☐ Yes ☐ No

4. Is the dependent capable of ANY employment? ☐ Yes ☐ No

   If yes, is the dependent employed? ☐ Yes ☐ No

   Where:

   Job description:

   Number of hours per week:

   Method of transportation to and from job (drives car, uses public transportation, uses special van (ie. "Handiwheels", etc.):

5. Does dependent have a diagnosis of intellectual disability? ☐ Yes ☐ No

6. Does dependent have a diagnosis of physical disability? ☐ Yes ☐ No

7. Does dependent have a diagnosis of any seizure disorder?

   ☐ Yes – If yes, when was the last seizure? ☐ No

   Medication, dose and frequency:

   Number of seizures per day:

8. Does dependent attend school?

   ☐ Yes – If yes, Where? ☐ No

   What grade level:

   Mainstream (in non special education class) experience:

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Subscriber's Statement – To Be Completed By Subscriber

9. Is dependent blind and/or deaf? ☐ Yes – Blind ☐ Yes – Deaf ☐ No
   If yes, does/did the dependent attend special education for the disability? ☐ Yes ☐ No

10. Was the dependent born with the disability? ☐ Yes ☐ No

11. Was the disability acquired? ☐ Yes ☐ No
    If yes:
    Where:

    When:

    How:

12. What is the dependent's level of activity for Activities of Daily Living (ADL's)?
    - ☐ Needs complete assistance in feeding, dressing, etc.
    - ☐ Needs partial assistance in feeding, dressing, etc.
    - ☐ Needs mental cueing to do activity
    - ☐ Needs assistance for mobility, does most ADL's independently (ie. needs assist to wheelchair, car, bed)

13. What is the expected date of improvement in condition or recovery?
    - ☐ Disability is considered permanent
    - ☐ Disability is of a nature that dependent status MIGHT change after sufficient education, and training
    - ☐ Disability is of a nature that dependent status WILL change after sufficient education, and training

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Physician Statement – To Be Completed By The Attending Physician

This is to certify that _____
has the specific diagnosis(es) (ICD-10)

☐ This dependent is receiving the following medications:

☐ The disability is of a permanent nature (ie. anacephalic, quadriplegia, intellectual disability) such that the dependent is incapable of self-support because of the intellectual disability or physical disability. This disability prevents him or her from engaging in ANY occupation or employment. (Be specific)

☐ The disability is of a partial nature (ie. blind, deaf, mild intellectual disability, etc.) (Be specific)

☐ There is potential for independent living with appropriate education at sometime in the future

I hereby authorize Doctor _____ to complete this form and forward it to:

- Blue Cross Blue Shield of North Dakota
  4510 13th Avenue South
  Fargo, North Dakota 58121

Subscriber Signature		**Date (mm/dd/yyyy)**	
Subscriber Address	City	State	Zip Code

Physician Signature	**Date (mm/dd/yyyy)**

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