Seneca Nation Disability Services
12837 Rt. 438 Irving, NY 14081 * 83 Wildwood Ave. Salamanca, NY 14779

Verification of Disability Form

Dear Medical Provider:

We ask your cooperation in providing the following information and returning it to the worker listed in the next section of this page. Your prompt return of this information will help to ensure timely processing of the application for assistance. Please mail the original form to the address listed above, or return by email or fax to the address/number provided in Section A. The applicant/recipient has consented to this release of information as shown in Section B.

A. APPLICANT/RECIPIENT INFORMATION (To be completed by Seneca Nation Disability Services)		
Applicant/Recipient Name:	Date of Birth	Case #:
Physical Address:		
Mailing Address:		
SNDS Worker: LEANNA LEROY or ASHLEY KETTLE	SNDS Phone #: 716-532-4900 Ext 5151	SNDS Fax #: 716-532-8329
Email Address: leanna.leroy@sni.org or ashley.kennedy@sni.org		

B. AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION (To be completed by the Applicant/Recipient)

I, _____, authorize the release of health care information related to my
PRINT NAME
physical and/or mental condition to Seneca Nation Disability Services as it pertains to my need for supportive services.

Signature: _____ Date: ____/____/____

Representative: _____ Date: ____/____/____
(if the individual is unable to sign)

C. HEALTH CARE INFORMATION (To be completed by a Licensed Health Care Professional ONLY)

The above-named individual has applied for or is currently receiving services from Seneca Nation Disability Services. In order for Supportive Services to be authorized or continued, a licensed health care professional must provide a health care certification declaring the individual above is unable to perform some activity of daily living independently and without this assistance the individual would be at risk of placement in out-of-home care. The SNDS worker has the responsibility for authorizing services and/or service hours. The information provided in this form will be considered as one factor of the need for services, and all relevant documentation will be considered in making the SNDS determination. SNDS Supportive Services include, but are not limited to: monetary supplemental assistance, home and/or personal care services, transportation and/or accompaniment to medical appointments/alternative resources, protective and prevention services, or any other service which an individual would normally perform or purchase for him/herself if he/she did not have functional and/or financial limitations, and which, due to his/her physical or mental condition, are necessary to maintain his/her health, safety, and independence.

*Licensed Health Care Professional means an individual licensed by the appropriate regulatory agency, acting within the scope of his or her license or certificate as defined in the Business and Professions Code. These include, but are not limited to: physicians, physician assistants, regional center clinicians or clinician supervisors, occupational therapists, physical therapists, psychiatrists, psychologists, optometrists, ophthalmologists and public health nurses.

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APPLICANT/RECIPIENT NAME: CASE #:

Please answer the following to the extent you are able, to further assist the SNDS worker in determining this individual's eligibility.
1. ___YES ___NO Has a disability, as defined by SNDS, which means; a. Inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months; or result in death.
2. ___YES ___NO Has a physical, mental, or emotional impairment that: a. Is expected to be of long-continued and indefinite duration; b. Substantially impedes his or her ability to live independently; and c. Is of such a nature that the ability to live independently could be improved by receiving supportive services.
3. ___YES ___NO Has a developmental disability as defined by SNDS, i.e., a person with a severe chronic disability that: a. Is attributable to a mental or physical impairment or combination of mental and physical impairments; b. Is manifested before the person attains age 19; c. Is likely to continue indefinitely; d. Results in substantial functional limitation in three or more of the following areas of major life activity: (1) Self-care, (2) Receptive and expressive language, (3) Learning, (4) Mobility, (5) Self-direction, (6) Capacity for independent living, and (7) Economic self-sufficiency; and e. Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are of lifelong or extended duration and are individually planned and coordinated.
4. ___YES ___NO Is the above a person whose disability is based solely on any drug or alcohol dependence (the person has no other disability which meets the above definitions).
5. Provide a description of any physical and/or mental condition or functional limitation that has resulted in or contributed to this individual's need for supportive services:
6. Describe the nature of the services you provide to this individual (e.g., medical treatment, nursing care, discharge planning, etc.:
7. How long have you provided service(s) to this individual?
8. Describe the frequency of contact with this individual (e.g. monthly, yearly, etc.)
9. Indicate the date you last provided services to this individual: ____/____/____

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APPLICANT/RECIPIENT NAME: CASE #:

D. LICENSED HEALTH CARE PROFESSIONAL CERTIFICATION		
By signing this form, I certify that I am a licensed health care professional and all information provided above is correct and true to my knowledge and records.		
Name:	Title:	
Address:		
Phone #:	Fax #:	
Signature:		Date:
Professional License #:	Licensing Authority:	

PLEASE RETURN COMPLETED FORM TO THE ODS WORKER LISTED IN SECTION A.