COLORADO
Department of Health Care Policy & Financing

Health First COLORADO
Colorado's Medicaid Program

Disability Determination Application

County use only:	County	Date of application

People who apply for help with their disability must meet financial **and** disability requirements. We will use the information you give on this application to make a **disability determination.**

What is a disability determination?

A disability determination checks if your medical condition qualifies you for Health First Colorado (Colorado's Medicaid program) benefits and services for your disability. Colorado also lets people qualify for limited disability if they are employed.

If you are not a Health First Colorado member:

- You will need to submit a Disability Determination application **and** a Health First Colorado application.
- Complete this Disability Determination application and **return it to your county department of human services.**
- The Health First Colorado application checks if you meet financial requirements. Find the Health First Colorado application at healthfirstcolorado.com/apply-now/. You can also get it from your county department of human services.
- Submitting the Disability Determination and Health First Colorado applications at the same time can help us make a decision faster. **Having a disability does not guarantee you will qualify.**

If you are already a Health First Colorado member:

- You do not have to complete a Health First Colorado application. Complete this Disability Determination application and **return it to your county department of human services.**

Tips for filling out the Disability Determination Application

- If you ever applied to the Social Security Administration (SSA) for Disability Benefits, **include copies of all letters and notices from SSA about your disability application.**
- **Do not leave answers blank unless the form tells you to skip a section.** If you do not know the answer, or the answer is "none" or "does not apply," write: "don't know" or "none" or "does not apply." **We will not process incomplete applications.**
- **Give complete contact information for each doctor on this application.** If you don't, we might not be able to get medical records from them that would help us decide your disability case.
  - All addresses must have a **ZIP code.**
  - All phone numbers must include **area code.**
- **Do not ask a doctor or hospital to complete this application.** You may get help from a friend, counselor, case manager, county worker or family member.
- **Provide complete dates (month/day/year),** and an explanation if the question asks for detail or if you want to give additional information.
- If you need more space or want to tell us more about an answer, **use the area in Section 8 Remarks.** Include the number of the question you are answering in more detail.

Tips for filling out the Disability Determination Application - (continued)

- You may send copies of any medical records you have with this application. If you don't have copies, the person who reviews your application can get them from your provider but this could delay processing time for your application.
- Many factors impact when your disability application review is completed. Include all needed medical information and records.

When you're done

- Fill this application completely. **We will not process incomplete applications.**
- You **must** sign in ink.
- Send the **completed and signed** Disability Determination application to your county department of human services. Find your county's contact info at CO.gov/cdhs/contact-your-county.

What happens next?

When the review of all your information is complete, you will get a letter to let you know if you qualify. If you disagree with the decision in the letter you can appeal it. Information on how to appeal will be in the letter.

Need help?

Complete as much of this application as you can. If you need help, contact your county department of human services. Find your county's contact info at CO.gov/cdhs/contact-your-county. For answers to frequently asked questions about disability determinations, go to hfcgo.com/disability-faqs.

Section 1 - Information About Your Disability

A. **Name** (First, middle initial, last)

B. **Social Security number**

☐ Check here if you are not eligible to receive an SSN, or if you refuse to get an SSN due to a well-established religious objection.

C. **Date of birth**	D. **Age**	E. **Gender**

F. **Mailing address** (Number, Street, Apt. No./Unit [if any], P.O. Box or Rural Route, City, State, ZIP)

G. **Email address**

H. Can you speak and understand English? ◯ Yes ◯ No (The reviewer will pay for an interpreter if they need to ask you a question about your application. See the page "Help In Your Language" at the end of this letter.)

If "No," **what language do you speak**? _____

I. Can you read English? ◯ Yes ◯ No Can you write in English? ◯ Yes ◯ No

J. **Daytime telephone number:** If you have no phone where you can be reached, please provide a daytime telephone number where we can leave a message for you.

(___)_____ This is ◯ My number ◯ Message number

K. If you would like a friend or relative who knows about your disabling conditions to help you with your application, please provide their information here so we can contact them.

Name _____ Relationship _____ Phone (___)_____

Address _____
(Number, Street, Apt. No./Unit [if any], P.O. Box, or Rural Route, City, State, ZIP)

If you are applying for a child, please fill out questions in L. If not, skip to Section 2.

L. Does the child live with you? ◯ Yes ◯ No If "No," fill out who the child lives with below.

Name _____ Relationship to child _____ Phone (___)_____

Address _____
(Number, Street, Apt. No./Unit [if any], P.O. Box, or Rural Route, City, State, ZIP)

Does the child have a legal guardian or custodian other than you? ◯ Yes ◯ No

Name _____ Relationship to child _____ Phone (___)_____

Address _____
(Number, Street, Apt. No./Unit [if any], P.O. Box, or Rural Route, City, State, ZIP)

Is there another adult who helps care for the child and can help us get information about the child if necessary? ◯ Yes ◯ No

Name _____ Relationship to child _____ Phone (___)_____

Address _____
(Number, Street, Apt. No./Unit [if any], P.O. Box, or Rural Route, City, State, ZIP)

Section 2 – Your Physical or Mental Disabling Conditions and Affects

A. What is your height without shoes: ____ Feet ____ Inches

B. What is your weight without shoes: ____ Pounds

C. What are your disabling conditions? Please list each condition separately. If you have cancer, please include the stage and type.

_____

_____

D. How do your disabling conditions limit your ability to work?

_____

_____

E. Do your disabling conditions cause you pain or other symptoms, such as seizures, etc.? ◯ Yes ◯ No

F. When did your disabling conditions first bother you? Month Day Year

G. When did you become unable to work because of your conditions? Month Day Year

H. Have you ever earned money from work, including self-employment? ◯Yes ◯No If "No," go to Section 4.

I. Did you work at any time after the date your disabling conditions first bothered you? ◯ Yes ◯ No

J. If "Yes," did your disabling conditions cause you to: (Check all that apply)

☐ Work fewer hours? (Explain below) ☐ Change your job duties? (Explain below)

☐ Make job-related changes such as attendance, help needed or change of employers? (Explain below)

_____

_____

K. Are you working now? ◯Yes ◯No

If "No," when did you stop working? Month Day Year

Why did you stop working? _____

L. Have you ever applied for Social Security Disability Income (SSDI) or Supplemental Security Income (SSI)? ◯ Yes ◯ No

If "Yes," on what date did you file the most recent application? Month Day Year

Is your Social Security application: ◯ Approved ◯ Denied ◯ Still pending

What was the date of their most recent decision? Month Day Year

If you appealed, on what date did you file the appeal? Month Day Year

If your Social Security claim was denied, are you experiencing new or worsening conditions? ◯ Yes ◯ No

If the response to the above question is "Yes," please provide a brief description of the new or worsening condition(s) **in Section 8 Remarks.**

If you have had SSDI or SSI and are no longer receiving it, why did your benefit stop?

_____

Please include copies of all letters from the Social Security Administration (SSA) about your disability application.

Section 3 - Information About Your Work

A. List the jobs (up to five), including sheltered work,* that you have had in the **15 years before you became unable to work** because of your physical, mental, emotional or learning disabling conditions. List your most recent job first.
*Sheltered work employs people with disabilities separately from others when they work.

☐ Not applicable. Check this box if you did not work at all in the 15 years before you became unable to work. Do not answer Section 3. Go to Section 4.

Job title *(See example)*	**Type of business**	**Dates worked** *(Month/year)* From	To	**Hours per day**	**Days per week**	**Rate of pay** *(Per hour, day, week, month or year)*	
Example: Cook	*Restaurant*	*May 2009*	*June 2012*	*8*	*5*	*$7.00*	*Hour*

B. Which job did you work the longest? _____

C. Describe this job. What did you do all day? If you need more space, **write in Section 8 Remarks.**

_____

_____

_____

_____

_____

_____

D. In this job, did you:

Use machines, tools or equipment? ○ Yes ○ No Use technical knowledge or skills? ○ Yes ○ No

Do any writing, complete reports or other similar duties? ○ Yes ○ No

E. In this job, how many **total** hours each day did you do each of the following:

Walk _____ Stand _____ Kneel (bend legs to rest on knees) _____

Sit _____ Climb _____ Handle, grab or grasp big objects _____

Reach overhead _____ Crouch (bend legs and back, down and forward) _____

Crawl (move on hands and knees) _____ Handle small objects, write or type _____

Stoop (bend down and forward at waist) _____

Section 3 (continued) - Information About Your Work

F. Lifting and carrying: Explain what you lifted, how far you carried it and how often you did this.

_____

_____

G. Check the heaviest weight you lifted:

○ Less than 10 pounds ○ 10 pounds ○ 20 pounds ○ 50 pounds ○ 100 pounds or more

H. Check the weight frequently lifted: (Frequently means from 1/3 to 2/3 of the workday.)

○ Less than 10 pounds ○ 10 pounds ○ 20 pounds ○ 50 pounds ○ 100 pounds or more

I. Did you supervise other people in this job? ○ Yes ○ No

If "No," go to Section 4; If "Yes," how many people did you supervise? _____

Did you hire and fire employees? ○ Yes ○ No

How much time was spent supervising people? _____ Hours

J. Please check if you have limitations in any of the areas below, otherwise check: ☐ No Limitations

☐ Breathing ☐ Seeing ☐ Hearing ☐ Speaking ☐ Concentrating

☐ Sleeping ☐ Eating ☐ Communicating ☐ Understanding ☐ Care for oneself

☐ Dealing with changes in routine work setting ☐ Performing manual tasks

☐ Responding appropriately to supervision ☐ Co-workers ☐ Work situations

☐ Other major bodily functions _____

Section 4 - Information About Your Medical Records

A. Has a doctor, hospital, clinic or anyone else seen you for physical, emotional or mental conditions, or learning disabilities that limit your ability to work? ○ Yes ○ No

If you answer "No" to this question, do not answer any more questions in Section 4.
Go to Section 5.

B. List other names you have used on your medical records including your maiden name, married names or nicknames. _____

Section 4 (continued) – Information About Your Medical Records

Tell us who may have medical records or other information about your disabling conditions.

C. **List each doctor, clinic, therapist and medical professional you have used.** Use an extra sheet if needed. Include the **date you last saw the provider and the date of your next appointment, if any.**

1. Name			Patient ID (if known)
Address			Date first seen
City	State	ZIP	Date last seen
Phone			Next appointment (if any)
Reason(s) for visits. What disabling conditions were treated or evaluated?			
What treatment did you receive?			

2. Name			Patient ID (if known)
Address			Date first seen
City	State	ZIP	Date last seen
Phone			Next appointment (if any)
Reason(s) for visits. What disabling conditions were treated or evaluated?			
What treatment did you receive?			

3. Name			Patient ID (if known)
Address			Date first seen
City	State	ZIP	Date last seen
Phone			Next appointment (if any)
Reason(s) for visits. What disabling conditions were treated or evaluated?			
What treatment did you receive?			

If you need more space, use Section 8 Remarks.

Section 4 (continued) – Information About Your Medical Records

D. List each hospital and any other health care facilities you have used (including emergency room visits, if any). Do not include anything you already listed in Section 4, Question C. List the most recent date first and include the type of visit.

1. Facility name		Phone
Address		
City	State	ZIP
Type of visit		
☐ Inpatient stay (Stayed at least overnight)	Date in	Date out
☐ Outpatient visit (Sent home same day)	Date of first visit	Date of last visit
☐ Emergency room visits (If occurred)	Date(s)	

2. Facility name		Phone
Address		
City	State	ZIP
Type of visit		
☐ Inpatient stay (Stayed at least overnight)	Date in	Date out
☐ Outpatient visit (Sent home same day)	Date of first visit	Date of last visit
☐ Emergency room visits (If occurred)	Date(s)	

Use Section 8 Remarks if you need more space for this information or for telling us about:

Other sources of medical information about your disabling condition from workers' compensation, vocational rehabilitation, insurance companies who have paid you disability benefits, prisons, attorneys, social service agencies and welfare. **Include all medical information, even if you aren't sure the information applies to your disability determination.** In Section 8, be sure to include:

- Organization or person's full name
- Phone number
- Address, city, state, ZIP code
- Name of contact person
- Claim or ID number (if any)
- Date of first contact
- Date of last contact
- Date of next contact (if any)
- Reasons for your visits

If this application is for a child, other sources of information about their disabling condition, from medical records or information about the child's illnesses, injuries or disabling conditions (foster parents, social workers, counselors, tutors, school nurses, detention centers, attorneys, insurance companies, and/or workers' compensation). If the child is scheduled to visit anyone else also include this information in Section 8. In Section 8, be sure to include

- Organization or person's full name
- Phone number,
- Address, city, state, ZIP code
- Name of contact person
- Claim or ID number (if any)
- Date of first contact
- Date of last contact
- Date of next contact (if any)
- Reasons for your visits

Section 5 - Information About Your Medical Tests

Have you had any medical tests for your disabling conditions?
◯ Yes (If "Yes," complete the information below.) ◯ No (If "No," go to Section 6.)

Kind of test	Date of test? (Month/day/year)	Name of facility where the test was done?	Who requested the test?
EKG (Heart test)			
Cardiac catheterization			
Treadmill (Exercise test)			
Biopsy: Name of body part _____			
Hearing test			
Vision test			
IQ test			
Speech/Language test			
EEG (Brain wave test)			
HIV test			
Blood test (Not HIV)			
Breathing test			
X-Ray: Name of body part _____			
MRI/CT Scan: Name of body part _____			
Other: Name of test and on what body part _____			

If you have had other tests, list them in Section 8 Remarks.

Section 6 - Information About Your Medications

Do you currently take medications for your disabling conditions? Include non-prescribed or "over the counter" medications. ◯ Yes ◯ No If "Yes," provide the information below, available on your medication bottle:

Name of medicine	Doctor name & phone (If prescribed)	Reason for medicine	Side effects experienced

Section 7 – Information About Your Education and Training

A. Check the highest grade of school completed and approximate date completed. Too young ☐

Grade School: College: Date completed: _____

Pre-K	K	1	2	3	4	5	6	7	8	9	10	11	12	GED	1	2	3	4	Advanced degrees
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

B. Did you attend any special education classes or complete any type of specialized job training, trade or vocational school? ○ Yes ○ No If "Yes," complete the following information:

School name _____

Address _____
(Number, Street, Apt. No./Unit [if any], P.O. Box, or Rural Route, City, State, ZIP)

Date attended _____ to _____ Type of program _____

If you have additional schools, **list them in Section 8 Remarks.**

If you are applying for a child, please fill out questions C-G. If not, skip to Section 8. If the child has an Individualized Education Program and/or an Individualized Family Service Plan, include those documents.

C. Is the child attending daycare/preschool? ○ Yes ○ No If "yes" complete the following:

Daycare/preschool/caregiver name _____ Phone (___)_____

Address _____
(Number, Street, Apt. No./Unit [if any], P.O. Box, or Rural Route, City, State, ZIP)

Dates attended _____ to _____ Teacher's/caregiver's name _____

D List the name of the school the child is currently attending and dates attended. If the child is no longer in school, list the name of the last school attended and dates attended.

School name _____ Phone (___)_____

Address _____
(Number, Street, Apt. No./Unit [if any], P.O. Box, or Rural Route, City, State, ZIP)

Dates attended _____ to _____ Teacher's name _____

E If child is not enrolled in school, please explain why _____

F. List the names of all **other** schools attended in the last 12 months and dates.

School name _____ Phone (___)_____

Address _____
(Number, Street, Apt. No./Unit [if any], P.O. Box, or Rural Route, City, State, ZIP)

Dates attended _____ to _____ Teacher's name _____

If you have additional schools, **list them in Section 8 Remarks.**

G. Has the child been tested for behavioral or learning problems? ○ Yes ○ No

Type of test _____ Test date _____

Type of test _____ Test date _____

Is the child in special education? ○ Yes ○ No If "yes" and different from above, name of special education teacher _____

Is the child in speech/language therapy? ○ Yes ○ No If "yes" and different from above, name of speech/language therapist _____

Section 8 – Remarks

Important note for all applicants: You must sign the medical release form and this application before it can be processed. Whether you complete Section 8 or not, use the next page to sign the application.

Use this Section 8 for additional information you did not share in earlier parts of this form or did not have room for. Include any additional information you want to add that may help us make a disability determination.

THIS APPLICATION MUST BE SIGNED

By signing this application, I affirm that everything is true to the best of my knowledge. I understand that I am giving the Colorado Department of Health Care Policy & Financing and its designees the authority to make the necessary contacts to verify any statements made on this application and to request all records/information necessary to make a disability determination. I understand submitting this application does not guarantee I will get any program benefits.

Signature of **applicant** or person filing on applicant's behalf **(parent/guardian)** 	**Date** (Month, day, year)

If you are unable to sign the application and have a representative sign on your behalf (i.e., Medical Power of Attorney (POA)/medical proxy/legal guardian, Guardian, Conservator, or General POA if the General POA has powers for insurance), you must also enclose copies of documentation that proves they are your Medical Power of Attorney/medical proxy/legal guardianship with this application. Do not send originals.

Witnesses are required **ONLY** if this statement has been signed by an (X) mark above. If signed by an (X) mark, two people who know the person making the statement must witness their signing and sign below themselves, including their addresses.

1. **Signature** of **Witness** 	2. **Signature** of **Witness** 
Address (Number, Street, Apt. No./Unit [if any], P.O. Box or Rural Route, City, State, ZIP)	**Address** (Number, Street, Apt. No./Unit [if any], P.O. Box or Rural Route, City, State, ZIP)

If you want or need someone to help with your Disability Determination Application, please complete this form.

You have the right to be assisted in the application process by the person of your choice.

I, _____, (print your name) name the following person to help me complete the Disability Application. I understand this person will have access to my protected health information. I understand that asking this person for help with the Disability Application does not mean this person is my Personal Representative.

_____ _____

Name of person helping with application | Relationship to applicant named above

_____

Telephone number of person helping with application

PURPOSE OR NEED FOR REQUESTED INFORMATION: This authorization is only for helping the applicant complete the Disability Application. It does not apply to any other medical information disclosure purpose. The information provided on the Disability Application will be shared with the Disability Determination vendor for the purpose of deciding if an applicant qualifies for health coverage. The final decision will be shared with the applicant or their legal representative at the address provided on the Disability Application.

EXPIRATION OF AUTHORIZATION: This authorization will expire one year from the date signed below or you may designate a shorter period of authorization here _____. You may also revoke this authorization at any time by contacting your county eligibility worker in writing.

I understand by signing this form that the person who helped me with this application may be contacted by the Disability Determination vendor or the Colorado Department of Health Care Policy & Financing.

I certify that I am making this request voluntarily and that the information I have provided is accurate to the best of my knowledge.

Date: _____

Applicant **signature**: _____

Parent, Legal Guardian, Power of Attorney or equivalent **signature:** _____

- Parent or Legal Guardian may sign on behalf of a minor child.
- Legal Guardian, Power of Attorney, or equivalent may sign on behalf of an adult. Please provide documentation that proves Legal Guardian or Power of Attorney status.

COLORADO
Department of Health Care Policy & Financing

Medical Records Release Form

Health First COLORADO™
Colorado's Medicaid Program

PERSON Whose records will be shared

Name (First, Middle, Last, Suffix)	Birthday (Month/Day/Year)
Social Security number ☐ Check here if you are not eligible to receive an SSN, or if you refuse to get an SSN due to a well-established religious objection.	

Authorization To Disclose Information To Arbor E & T, LLC, dba Action Review Group (ARG)
** Please Read The Entire Form, Both Pages, Before Signing **

I voluntarily authorize and request disclosure (including paper, oral and electronic interchange):

OF WHAT All my medical records, education records and other information related to my **ability to perform tasks (including paper, oral and electronic interchange records). This includes specific permission to release:**

1. **All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s) including, and not limited to:**
   - Psychological, psychiatric or other mental impairment(s) (excludes "psychotherapy notes" as defined in 45 CFR 164.501)
   - Drug abuse, alcoholism, or other substance abuse
   - Sickle cell anemia
   - Records which may indicate the presence of a communicable or noncommunicable disease; and tests for or records of HIV/AIDS
   - Gene-related impairments (including genetic test results)
2. **Information about how my impairment(s) affects my ability to complete tasks and activities of daily living, and affects my ability to work.**
3. **Copies of educational tests or evaluations, including Individualized Educational Programs, triennial assessments, psychological and speech evaluations, and any other records that can help evaluate function; also teachers' observations and evaluations.**
4. **Information created within 12 months after the date this authorization is signed, as well as past information.**

FROM WHOM

- **All medical sources** (hospitals, clinics, labs, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, and VA health care facilities
- All educational sources (schools, teachers, records administrators, counselors, etc.)
- Social workers/rehabilitation counselors
- Consulting examiners used by ARG
- Employers, insurance companies, workers' compensation programs
- Others who may know about my condition
- (family, neighbors, friends, public officials)

THIS BOX TO BE COMPLETED BY ARG (as needed) Additional information to identify the subject (e.g., other names used), the specific source, or the material to be disclosed:

TO WHOM **The state contractor authorized to process my case, including contract copy services, and doctors or other professionals consulted during the process.** (Also, for international claims, to the U.S. Department of State Foreign Service Post.)

PURPOSE **Determining my eligibility for benefits,** including looking at the combined effect of any impairments that by themselves would not meet SSA's definition of disability; and whether I can manage such benefits. I understand that I don't have to sign this authorization. If I don't sign it, the benefits, treatment, and provider payments I am eligible for will not be affected.

☐ Determining whether I am **capable of managing benefits ONLY** (check only if this applies)

EXPIRES WHEN **This authorization is good for 12 months from the date signed** (below my signature).

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be redisclosed to other parties and no longer protected.
- I may write to ARG and my sources to revoke this authorization at any time (see page 3 for details).
- ARG will give me a copy of this form if I ask; I may ask the source to allow me to inspect or get a copy of material to be disclosed.
- **I have read both pages of this form and agree to the disclosures above from the types of sources listed.**

PLEASE SIGN USING BLUE OR BLACK INK ONLY **INDIVIDUAL authorizing disclosure**	**IF not signed by subject of disclosure,** specify basis for authority to sign ◯ Parent of minor ◯ Guardian ◯ Other personal representative (explain below) Parent/guardian/personal representative **SIGN here** if two signatures required by State law.

Date signed	Street address	
Phone number (w/ area code)	City State ZIP	
I know the person signing this form or am satisfied of this person's identity. **WITNESS SIGN**		Phone number (or address)
IF needed, second witness sign here (e.g., if signed with "X" above) **SIGN**		Phone number (or address)

This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under P.L. 104-191 ("HIPAA"); 45 CFR parts 160 and 164; 42 U.S. Code section 290dd-2; 42 CFR part 2; 38 U.S. Code section 7332; 38 CFR 1.475; 20 U.S. Code section 1232g ("FERPA"); 34 CFR parts 99 and 300; and State law.

Explanation of this form

"Authorization to Disclose Information to ARBOR E & T, LLC dba ACTION REVIEW GROUP (ARG)"

We need your written authorization to help get the information required to process your claim, and to determine your capability of managing benefits. Laws and regulations require that sources of personal information have a signed authorization before releasing it to us. Also, laws require specific authorization for the release of information about certain conditions and from educational sources.

You can provide this authorization by signing this form. Federal law permits sources with information about you to release that information if you sign a single authorization to release all your information from all your possible sources. We will make copies of it for each source. A covered entity (that is, a source of medical information about you) may not condition treatment, payment, enrollment, or eligibility for benefits on whether you sign this authorization form. A few States, and some individual sources of information, require that the authorization specifically name the source that you authorize to release personal information. In those cases, we may ask you to sign one authorization for each source and we may contact you again if we need you to sign more authorizations.

You have the right to revoke this authorization at any time, except to the extent a source of information has already relied on it to take an action. To revoke, send a written statement to Arbor E & T, LLC dba Action Review Group (ARG). If you do, also send a copy directly to any of your sources that you no longer wish to disclose information about you; Arbor E & T, LLC dba Action Review Group (ARG).can tell you if we identified any sources you didn't tell us about. Arbor E & T, LLC dba Action Review Group (ARG).may use information disclosed prior to revocation to decide your claim.

It is Arbor E & T, LLC dba Action Review Group (ARG)'s policy to provide service to people with limited English proficiency in their native language or preferred mode of communication consistent with Executive Order 13166 (August 11, 2000) and the Individuals with Disabilities Education Act. Arbor E & T, LLC dba Action Review Group (ARG) makes every reasonable effort to ensure that the information in the Arbor E & T, LLC dba Action Review Group (ARG) is provided to you in your native or preferred language.

Privacy Act Statement – Collection and Use of Personal Information - Sections 205(a), 233(d)(5)(A), 1614(a)(3)(H)(i), 1631(d)(l) and 1631(e)(l)(A) of the Social Security Act as amended, [42 U.S.C. 405(a), 433(d) (5)(A), 1382c(a)(3)(H)(i), 1383(d)(l) and 1383(e)(l)(A)] authorize us to collect this information. We will use the information you provide to help us determine your eligibility, or continuing eligibility for benefits, and your ability to manage any benefits received. The information you provide is voluntary. However, failure to provide the requested information may prevent us from making an accurate and timely decision on your claim, and could result in denial or loss of benefits.

We rarely use the information you provide on this form for any purpose other than for the reasons explained above. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, including but not limited to the following:

1. To enable a third party or an agency to assist us in establishing rights to Social Security benefits and/or coverage;
2. To comply with Federal laws requiring the release of information from our records (e.g., Social Security Audits / Reviews, Appeals)
3. To make medical determinations of disability based upon available medical records.

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. We use the information from these programs to establish or verify a person's current disability status with those agencies. A complete list of routine uses of the information you give us is available by request by contacting Arbor E & T, LLC dba Action Review Group (ARG).

Arbor E & T, LLC dba Action Review Group (ARG) is a partner with and contracted by the State of Colorado's Department of Health Care Policy and Financing (HCPF) to perform medical records review services to determine the level and severity of disability according to the criteria and rules established by the Social Security Administration. Your records are available to HCPF for review and audit. The laws, rules, and regulations stated in the document also apply to HCPF. Arbor E & T, LLC dba Action Review Group (ARG) does NOT provide nor establish eligibility for any Health First Colorado (Colorado's Medicaid program) or Medicare benefits or programs.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. We estimate that it will take about 10 minutes to read the instructions, gather the facts, and answer the questions.

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Help in your Language

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አማርኛ	ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡
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