Disability Application

COLORADO
Department of Health Care Policy & Financing

Health First COLORADO
Colorado's Medicaid Program

County use only:	County	Date of application

This Health First Colorado (Colorado's Medicaid program) Disability Determination Application must be submitted to your county office.

Only completed and signed applications will be processed.

IF YOU NEED HELP

If you need help with this application, contact your county department of human services. Please complete as much as you can before contacting your county technician. Find your county's contact info at CO.gov/cdhs/contact-your-county.

HOW TO COMPLETE THIS APPLICATION

The information you give on this application will be used to decide if you meet the disability criteria for Health First Colorado (Colorado's Medicaid program) benefits. Colorado also allows people to qualify for limited disability if they are employed. Your financial eligibility will be determined separately from this application. **Please remember that having a disability does not guarantee you will qualify for Health First Colorado enrollment.**

- 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.** If you do not know the answer, or the answer is "none" or "does not apply," please write: "don't know" or "none" or "does not apply."
- Each address should include a **ZIP code.** Each phone number should include an **area code.** You must provide complete information for each doctor you identify on this application. Failure to provide complete information may result in those medical records not being used to make a decision on your case.
- **Do not ask a doctor or hospital to complete this application.** You may get help from a friend, counselor, case manager, county technician or family member.
- Be sure to **show complete dates (month/day/year),** and provide 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, **please use the Section 8 Remarks** on page 10. Provide the number of the question being answered.
- 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 free of charge.
- There are many factors that impact when your disability application review is completed, including obtaining all needed medical information. When the review is complete, you will be notified by letter.

Sign up to get helpful information about your Health First Colorado benefits by text! Text "JOIN" to 66596. Message and data rates may apply.

Section 1 - Information About Your Disability

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

B. **Social Security number**

Check here if not eligible to receive a SSN or refuse to obtain due to 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. Refer to "Help In Your Language" on page 15.)

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? MM/ DD/ YYYY

G. When did you become unable to work because of your conditions? MM/ DD/ YYYY

H. Have you ever worked, including self-employment that gave you earned income? 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? MM/ DD/ YYYY

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? MM/ DD/ YYYY

Is your Social Security claim: Approved Denied Still pending

What was the date of their most recent decision? MM/ DD/ YYYY

If you appealed, on what date did you file the appeal? MM/ DD/ YYYY

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 and notices from 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 is an employer that employs people with disabilities separately from others.**

Not applicable if you did not work at all in the 15 years before you became unable to work. Do not answer Section 3 and 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*	*9/99*	*10/02*	*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 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," complete the following.

How many people did you supervise? _____

Did you hire and fire employees? Yes No

What part of your time was spent supervising people? _____ Hours

J Please check if limitations exist 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. Have you been seen by a doctor, hospital, clinic or anyone else for the physical, emotional, mental or learning disabling conditions that limit your ability to work? Yes No

If you answered "No" to this question, go to Section 5.

B. List other names you have used on your medical records including your maiden, 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 the provider was last seen and date of your next appointment, if any.**

1. Name			Patient ID (if known)
Street 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 was received?			

2. Name			Patient ID (if known)
Street 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 was received?			

3. Name			Patient ID (if known)
Street 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 was received?			

If you need more space, use Section 8 Remarks.

Section 4 (continued) – Information About Your Medical Records

D. List each hospital and other health care facilities you have used (including emergency room visits, if occurred), unless listed in Section 4, Question C. List the most recent date first and include type of visit.

1. Facility name		Phone
Street 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
Street 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)	

If you need more space for this information or telling us about other sources of medical information about you from workers' compensation, vocational rehabilitation, insurance companies who have paid you disability benefits, prisons, attorneys, social service agencies and welfare, **use Section 8 Remarks.** Be sure to include organization, phone, 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 contacts.

If a child, does anyone else have 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), or is the child scheduled to visit anyone else? **If so, please include in Section 8 Remarks** with organization, phone, 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 contacts.

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)	Where was test done? (Name of facility)	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, state reason 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

Use this section for additional information you did not share in earlier parts of this form or did not have room for. Include any additional information for which there was not enough room in previous sections, or if you have additional information you want to include that may help making a disability determination. After completing this section (or if you don't have anything to add), sign below and go to the next page. **You must sign this application before it can be considered a completed Disability Application ready for review.**

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 determine medical disability eligibility. I understand that this application does not guarantee any program benefits on my behalf.

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 (i.e., Medical Power of Attorney (POA)/medical proxy/legal guardian, Guardian, Conservator or General POA if the General POA has powers for insurance) sign on your behalf, you must also enclose copies of documentation that establishes them as your Medical Power of Attorney/medical proxy/legal guardianship with this application.

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.

Signature of **Witness**	**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 Determination Application which includes sharing my protected health information that will help establish health care coverage eligibility. This form does not designate a person as 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 to help the applicant complete the Disability Determination Application and does not apply to any other medical information disclosure purpose. The information provided on the Disability Determination Application will be shared with the Disability Determination vendor for the purpose of determining disability eligibility for health care coverage. The final determination will be shared with the applicant or their legal representative at the address provided on the Disability Determination 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 this request has been made voluntarily and that the information given 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 minor child. Legal Guardian, Power of Attorney, or equivalent may sign on behalf of adult – **documentation is required.**

COLORADO
Department of Health Care Policy & Financing

Medical Records Release Form

Health First COLORADO
Colorado's Medicaid Program

WHOSE Records to be disclosed

NAME (First, Middle, Last, Suffix)	Birthday (MM/DD/YYYY)
Social Security number	Check here if not eligible to receive a SSN or refuse to obtain due to 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; also education records and other information related to my ability to perform tasks. 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.

SEND OR BRING THE COMPLETED FORM TO ARBOR E & T, LLC dba ACTION REVIEW GROUP (ARG), P.O. BOX 340, OLYPHANT, PA 18447 or FAX THIS FORM TO ARG AT 1.877.672.2077. You may call ARG at 1.877.265.1864 and email ARG at actionreviewgroupmrt@arboret.com

Help in your Language

Health Care Policy and Financing: 1-800-221-3943 (State Relay: 711)	
Español	ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.
Tiếng Việt	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn.
繁體中文	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。
한국어	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
Русский	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.
አማርኛ	ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡
العربية	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان.
Deutsch	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.
Français	ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement.
नेपाली	ध्यान दिनुहोस्: तपाईले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ ।
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.
日本語	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。
Oroomiffa	XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama.
فارسی	**توجه**: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد.
Polski	UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej.