ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Family Assistance Administration

VERIFICATION OF DISABILITY

↳ **Local Office Return Address** ↴
(Use the DES-166 envelope)

Date of Request:	
Applicant/Patient's Name *(Last, First, M.I.)*:	
Case Number:	Mail Drop:
Worker's Name:	
Phone Number:	

All information above Part A is to be completed by FAA.

☐ **Medical Assistance**
☐ **Cash Assistance**

In order to determine eligibility for services for the person named above, the Department of Economic Security (DES) is requesting that you provide the following information. Any information provided will be kept confidential except from this person and/or person's representative, unless you indicate that such information would be detrimental to his/her well-being, or mental or physical health. In that case the information will be kept totally confidential.

PART A. PATIENT'S/APPLICANT'S AUTHORIZATION

I authorize the hospital, medical group, or above-named physician to release to DES, to be included in my permanent file, any or all information, records, documents, reports, histories and charts relating to the medical treatment I have received.

I understand that I may revoke this authorization at any time. However, any information gathered prior to the revocation will remain in my permanent file.

Autorizo al hospital, grupo médico o doctor que aquí aparece que le entregue al DES, para incluir en mi archivo permanente toda información, archivos, documentos, informes, historiales y diagramas relacionados al tratamiento médico que he recibido.

Entiendo que puedo revocar esta autorización en cualquier momento. Sin embargo, toda información conseguida antes de la revocación permanecerá en mi archive permanente.

Printed Name (*Su nombre en letra de imprenta*): _____

Patient's Signature/*Firma del paciente*: _____ Date/*Fecha*: _____

REVOCATION OF AUTHORIZATION

☐ **I wish to revoke the authorization granted above. *Deseo revocar está autorización.***

Printed Name (*Su nombre en letra de imprenta*): _____

Patient's Signature/*Firma del paciente*: _____ Date/*Fecha*: _____

PART B. MEDICAL INFORMATION TO BE COMPLETED BY MEDICAL PERSONNEL

1. Does the patient have a physical or mental incapacity which prevents him/her from performing any substantially gainful employment? ☐ Yes ☐ No
2. If the term of incapacity can now be determined, please indicate when the patient will again be able to work?

   _____
3. If the term of incapacity cannot be determined at the present time, please indicate when (month/year) the patient needs to be re-examined and reevaluated: _____

See page 2 for USDA/EOE/ADA/LEP/GINA disclosures
Vea la página 2 para leer la declaración de USDA/EOE/ADA/LEP/GINA

Diagnosis and Prognosis:

Signature of Physician Authorized Medical Personnel: _____

Printed Name of Physician Authorized Medical Personnel: _____

Title *(Please print)*: _____

Phone Number: _____ Date: _____