COUNTY OF SAN BERNARDINO

STANDARD PRACTICE

NO 13-4.10	ISSUE
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	EFFECTIVE 7/15/97
DEPARTMENT ~~BEHAVIORAL HEALTH~~	APPROVED James McReynolds, Director
SUBJECT DISABILITY APPLICATION	

I. PURPOSE

To ensure that Department of Behavioral Health clients' applications for disability are handled properly.

II. POLICY

Department of Behavioral Health clients should be evaluated for disability by San Bernardino County Department of Behavioral Health psychiatrists. The disability forms are as follows:

1. Medi-Cal
2. State Disability Insurance
3. Motor Vehicle Department Disability Verification
4. Aid for Dependent Children
5. Food Stamps
6. Off-Work Orders (Outpatient off-work orders should be given for the day the patient is seen.)
7. Omni Trans (See attached)
8. Long Term Disability Forms

A. No client should be certified by San Bernardino County Department of Behavioral Health Psychiatrists when seen for the first time in the clinic. Determination of a mental disability will required continued treatment.

B. DPSS/SSI (Social Security/Disability) and other misc. Forms will be completed for clients only after 60 days in uninterrupted treatment. (Or ongoing treatment.)

C. GENERAL RELIEF may be completed at any time if the treatment staff feels General Relief is warranted. Approval should not be given for mor than 90 days at a time and then reviewed again while client is in continued treatment.

III. PROCEDURE

A. Clients are not given the completed forms to hand carry. Completed disability forms are sent directly to Social Security by the correspondence clerk. This must be documented in the Release of Information Log and recorded in the client's chart.

B. **A valid release of information must be completed by the client. Complete instruction on this procedure is in the Administrative Procedure Manual, Medical Record Section 7, "Authorization - Consent to Release Confidential Information".**

C. **TO WHOM IT MAY CONCERN LETTERS: "...such letters should be provided for the following purposes:**

- **clearance to enroll into drug/alcohol rehabilitation program.**
- **Exceptional case per physician's discretion.**

CD:jmp
a:disblty.spm

DISABILITY INFORMATION RELEASE

If you do not have an acceptable proof of disability, please complete this form and return to Omnitrans. Omnitrans will then contact your physician/social worker to verify your disability.

When Omnitrans receives verification of your disability, you will be contacted and issued an Omnitrans Disabled I.D. card.

PLEASE PRINT CLEARLY OR TYPE

NAME ____

ADDRESS ____

CITY ____________________ **ZIP CODE** ________

PHONE ____________________ **DATE OF BIRTH** ____________________

PARENT/GUARDIAN/CARE PROVIDER NAME ____________________

MEDI-CAL NUMBER ____

HEIGHT __________ **WEIGHT** __________ **EYE COLOR** __________

I AUTHORIZE ____
Physician's name/social worker's name

____
Physician's/social worker's address

to release information verifying my disability to Omnitrans.

____________________ Signature ____________________ Date

Mail this form to: Omnitrans
Attn: Marketing Dept
1700 W. Fifth St
San Bernardino, CA 92411
(909)889-0811

PHYSICIAN'S/AGENCY STATEMENT

DATE:__________________

I certify that ____________________________ ____________________________
(Patient's/Client's Name) (Address)

meets the Omnitrans' eligibility criteria:

Check where applicable:

[] Non-Ambulatory Disabilities [] Semi-Ambulatory

[] Visual Disabilities (visual acuity of 20/200 or less)

[] Hearing Disabilities (Hearing loss of 90 dba or greater)

[] Mental Disabilities [] Confined to wheelchair

[] Regularly used a walker or [] Other aid to mobility

Explanation of Disability

____

____

Is your patient/client disabled: [] PERMANENTLY [] TEMPORARILY
If temporary, how long?____________________________

____
Physician's/Social Worker's Signature If applicable, Agency Name

____
Address City

____
Telephone number

Mail this form to: Omnitrans
1700 W. Fifth
San Bernardino
CA, 92411