NMI SETTLEMENT FUND

POST OFFICE BOX 501247, SAIPAN, MP 96950

DISABILITY REPORT FORM

SECTION 1 – INFORMATIONABOUT THE DISABLED PERSON

☐ **PLEASE MARK THE BOX WITH AN X OR ✓ IF THIS FORM IS BEING COMPLETED BY SOMEONE ELSE BECAUSE THE APPLICANT CANNOT READ OR UNDERSTAND ENGLISH. INDICATE ACCORDINGLY IN SECTION H BELOW.**

A. NAME: (*FIRST, MIDDLE INITIAL, LAST)*

B. SOCIAL SECURITY NUMBER:

C. DAYTIME TELEPHONE NUMBER *(If you have no number where you can be reached, give us a daytime number where we can leave a message for you.)* (_____) _____ ☐ **Your Number** ☐ **Message Number** ☐ **None**

D. GIVE THE NAME OF A FRIEND OR RELATIVE THAT WE CAN CONTACT (OTHER THAN YOUR DOCTOR) WHO KNOWS ABOUT YOUR ILLNESS, INJURIES OR CONDITIONS AND CAN HELP YOU WITH YOUR CLAIM.

NAME: _____ **RELATIONSHIP:** _____

ADDRESS: _____

(Number, Street, Apt. No. (If any), P.O. Box, or Rural Route)

DAYTIME PHONE: (_____) _____

Area Code *Number*

E. WHAT IS YOUR *HEIGHT* WITHOUT SHOES?

_____ ' _____ "

F. WHAT IS YOUR *WEIGHT* WITHOUT SHOES?

_____ ***pounds***

G. DO YOU HAVE A MEDICAL ASSISTANCE CARD? (For Example, Medicaid or Aetna) If "YES," show the number here:

☐ **YES** ☐ **NO** _____

H. CAN YOU SPEAK AND UNDERSTAND ENGLISH? ☐ **YES** ☐ **NO** **IF "NO," WHAT IS YOUR PREFERRED LANGUAGE?** _____

NOTE: IF YOU CANNOT SPEAK AND UNDERSTAND ENGLISH, WE WILL PROVIDE AN INTERPRETER, FREE OF CHARGE.

If you cannot **speak and understand English,** is there someone we can contact who speaks and understands English and will give you message? ☐ **YES** ☐ **NO** *(If "YES," and that person is the same as in "D" above show "SAME" here. If not, complete the following information.)*

NAME: _____ **RELATIONSHIP:** _____

ADDRESS: _____

(Number, Street, Apt. No. (If any), P.O. Box, or Rural Route)

DAYTIME PHONE: (_____) _____

Area Code *Number*

I. CAN YOU READ AND UNDERSTAND ENGLISH?

☐ **YES** ☐ **NO**

J. CAN YOU WRITE MORE THAN YOUR NAME IN ENGLISH?

☐ **YES** ☐ **NO**

Tel: 670.322.3863 ▪ Fax: 670.664.8080

SECTION 2
YOUR ILLNESSES, INJURIES OR CONDITIONS AND HOW THEY AFFECT YOU

A. WHAT ARE THE ILLNESSES, INJURIES OR CONDITIONS THAT LIMIT YOUR ABILITY TO WORK?

B. HOW DO YOUR ILLNESSES, INJURIES OR CONDITIONS LIMIT YOUR ABILITY TO WORK?

C. DO YOUR ILLNESSES, INJURIES OR CONDITIONS CAUSE YOU PAIN OR OTHER SYMPTOMS? ☐ **YES** ☐ **NO**

D. WHEN DID YOUR ILLNESS, INJURIES OR CONDITIONS FIRST BOTHER YOU?

Month	*Day*	*Year*

E. WHEN DID YOU BECOME UNABLE TO WORK BECAUSE OF YOUR ILLNESS, INJURIES OR CONDITIONS?

Month	*Day*	*Year*

F. HAVE YOU EVER WORKED? ☐ **YES** ☐ **NO** *(If "NO." go to Section 4.)*

G. DID YOU WORK AT ANY TIME AFTER THE DATE YOUR ILLNESSES, INJURIES OR CONDITIONS FIRST BOTHERED YOU? ☐ **YES** ☐ **NO**

H. IF "YES," DID YOUR ILLNESS, INJURIES OR CONDITIONS CAUSE YOU TO: *(check all that apply)*

☐ **work fewer hours?** *(Explain below)*

☐ **change your job duties?** *(Explain below)*

☐ **make any job-related changes such as your attendance, help needed, or employers?** *(Explain below)*

I. ARE YOU WORKING NOW? ☐ **YES** ☐ **NO**

IF "NO," WHEN DID **YOU STOP** WORKING?

Month	*Day*	*Year*

J. WHY DID YOU STOP WORKING?

SECTION 3 – INFORMATION ABOUT YOUR WORK

A. LIST ALL THE JOBS THAT YOU HAD IN THE 15 YEARS BEFORE YOU BECAME UNABLE TO WORK BECAUSE OF YOUR ILLNESS, INJURIES OR CONDITIONS.

JOB TITLE *(Example: Carpenter)*	TYPE OF BUSINESS/GOV'T AGENCY *(Example: Restaurant, DPW)*	DATES WORKED (month & year)		HOURS PER DAY	DAYS PER WEEK	RATE OF PAY (Per hour, day, week, month, or year)	
		From	To				
						$	
						$	
						$	
						$	
						$	
						$	
						$	
						$	

B. WHICH JOB DID YOU HOLD OR PERFORM THE LONGEST? _____

C. DESCRIBE THIS JOB. WHAT DID YOU DO ALL DAY? (If you need more space, write in the "Remarks" section.)

_____

_____

_____

_____

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 similar duties? ☐ **YES** ☐ **NO**

E. IN THIS JOB, HOW MANY TOTAL <u>HOURS</u> EACH DAY DID YOU:

Walk? _____ Skoop? *(Bend down & forward at waist.)* _____ Handle, grab or grasp big objects? _____

Stand? _____ Kneel? *(Bend legs to rest on knees.)* _____ Reach? _____

Sit? _____ Crouch? *(Bend legs & back down & forward.)* _____ Write, type or handle small objects? _____

Climb? _____ Crawl? *(Move on hands & knees.)* _____

SECTION 3 – INFORMATION ABOUT YOUR WORK (Continuation)

F. LIFTING AND CARRYING *(Explain what you lifted, how far you carried it, and how often you did this.)*

G. CHECK HEAVIEST WEIGHT LIFTED:

☐ Less than 10 lbs ☐ 10 lbs ☐ 20 lbs ☐ 50 lbs ☐ 100 lbs ☐ Other _____ lbs

H. CHECK WEIGHT FREQUENTLY LIFTED: *(By frequently, we mean from 1/3 to 2/3 of the workday.)*

☐ Less than 10 lbs ☐ 10 lbs ☐ 20 lbs ☐ 50 lbs ☐ 100 lbs ☐ Other _____ lbs

I. DID YOU SUPERVISE OTHER PEOPLE IN THIS JOB?

How many people did you supervise? _____
What part of your time was spent supervising people? _____
Did you hire and fire employees? ☐ **YES** ☐ **NO**

J. WERE YOU A LEAD WORKER? ☐ **YES** ☐ **NO**

SECTION 4 – INFORMATION ABOUT YOUR MEDICAL RECORDS

A. HAVE YOU BEEN SEEN BY A DOCTOR/HOSPITAL/CLINIC OR ANYONE ELSE FOR THE ILLNESSES, INJURIES OR CONDITIONS THAT LIMIT YOUR ABILITY TO WORK? ☐ **YES** ☐ **NO**

B. HAVE YOU BEEN SEEN BY A DOCTOR/HOSPITAL/CLINIC OR ANYONE ELSE FOR EMOTIONAL OR MENTAL PROBLEMS THAT LIMIT YOUR ABILITY TO WORK? ☐ **YES** ☐ **NO**

IF YOU ANSWERED "NO" TO BOTH OF THESE QUESTIONS, GO TO SECTION 5.

C. LIST OTHER NAMES YOU HAVE USED ON YOUR MEDICAL RECORDS. _____

_____

_____

Tell us who may have medical records or other Information about your illnesses, injuries or conditions

D. List each DOCTOR/HMO/THERAPIST/OTHER. Include your **next appointment.**

1.

NAME :			**DATES**
STREET ADDRESS			**FIRST VISIT**
CITY	**STATE**	**ZIP**	**LAST SEEN**
PHONE: (_____) _____ *Area Code* *Number*	**PATIENT ID#** (If Known)		**NEXT APPOINTMENT**
REASON(S) FOR VISITS			
WHAT **TREATMENT** WAS RECEIVED?			

SECTION 4 – INFORMATION ABOUT YOUR MEDICAL RECORDS (Continuation)

2.

NAME :			DATES
STREET ADDRESS			FIRST VISIT
CITY	STATE	ZIP	LAST SEEN
PHONE: (_____) _____ *Area Code* *Number*	PATIENT ID# (If Known)		NEXT APPOINTMENT
REASON(S) FOR VISITS			
WHAT TREATMENT WAS RECEIVED?			

3.

NAME :			DATES
STREET ADDRESS			FIRST VISIT
CITY	STATE	ZIP	LAST SEEN
PHONE: (_____) _____ *Area Code* *Number*	PATIENT ID# (If Known)		NEXT APPOINTMENT
REASON(S) FOR VISITS			
WHAT TREATMENT WAS RECEIVED?			

If you need more space, use Remarks, Section 9.

SECTION 4 – INFORMATION ABOUT YOUR MEDICAL RECORDS (Continuation)

E. List each HOSPITAL/CLINIC. Include your **next appointment.**

HOSPITAL/CLINIC			TYPE OF VISIT	DATES	
NAME			☐ **INPATIENT** STAYS (Stayed at least overnight)	**DATE IN**	**DATE OUT**
STREET ADDRESS			☐ **OUTPATIENT** VISITS *(Sent home same day)*	**DATE FIRST VISIT**	**DATE LAST VISIT**
CITY	**STATE**	**ZIP**			
			☐ **EMERGENCY ROOM** VISITS	**DATE OF VISITS**	
PHONE (_____) _____ *Area Code* *Number*					

NEXT APPOINTMENT _____ **YOUR HOSPITAL/CLINIC NUMBER** _____

REASON(S) FOR VISITS

_____

_____

_____

WHAT TREATMENT DID YOU RECEIVE? _____

_____

_____

WHAT DOCTORS DO YOU SEE AT THIS HOSPITAL/CLINIC ON A REGULAR BASIS? _____

_____

_____

HOSPITAL/CLINIC			TYPE OF VISIT	DATES	
NAME			☐ **INPATIENT** STAYS (Stayed at least overnight)	**DATE IN**	**DATE OUT**
STREET ADDRESS			☐ **OUTPATIENT** VISITS *(Sent home same day)*	**DATE FIRST VISIT**	**DATE LAST VISIT**
CITY	**STATE**	**ZIP**			
			☐ **EMERGENCY ROOM** VISITS	**DATE OF VISITS**	
PHONE (_____) _____ *Area Code* *Number*					

NEXT APPOINTMENT _____ **YOUR HOSPITAL/CLINIC NUMBER** _____

REASONS FOR VISITS _____

NEXT APPOINTMENT _____ **YOUR HOSPITAL/CLINIC NUMBER** _____

REASONS FOR VISITS _____

_____

_____

WHAT TREATMENT DID YOU RECEIVE? _____

_____

_____

WHAT DOCTORS DO YOU SEE AT THIS HOSPITAL/CLINIC ON A REGULAR BASIS? _____

_____

_____

_____

_____

If you need more space, use Remarks, Section 9.

F. Does **anyone else have medical records or information** about your illnesses, injuries or conditions (Workers' Compensation, insurance companies, prisons, attorneys, welfare), or are you scheduled to see anyone else?

☐ **YES** *(If "YES," complete information below.)* ☐ **NO**

NAME :			**DATES**
STREET ADDRESS			**FIRST VISIT**
CITY	**STATE**	**ZIP**	**LAST SEEN**
PHONE: (_____) _____ *Area Code* *Number*	**PATIENT ID#** (If Known)		**NEXT APPOINTMENT**
CLAIM NUMBER (If any)			
REASON(S) FOR VISITS			

If you need more space, use Remarks, Section 9.

SECTION 5 – MEDICATIONS

DO YOU CURRENTLY TAKE ANY **MEDICATIONS** FOR YOUR ILLNESSES, INJURIES OR CONDITIONS? ☐ **YES** ☐ **NO**
If "YES," please tell us the following: *(Look at your medicine bottles, if necessary.)*

NAME OF MEDICINE	IF PRESCRIBED GIVE NAME OF DOCTOR	REASON FOR MEDICINE	SIDE EFFECTS YOU HAVE

If you need more space, use Remarks, Section 9.

SECTION 6 – TESTS

HAVE YOU HAD, OR WILL HAVE, ANY **MEDICAL TESTS** FOR YOUR ILLNESSES, INJURIES OR CONDITIONS? ☐ **YES** ☐ **NO**
If "YES," please tell us the following: *(Look at your medicine bottles, if necessary.)*

KIND OF TEST	WHEN DONE, OR WHEN WILL IT BE DONE? (Month, day, year)	WHEN DONE? (Name of Facility)	WHO SENT YOU FOR THIS TEST?
EKG (HEART TEST)			
TREADMILL (EXERCISE TEST)			
CARDIAC CATHERIZATION			
BIOPSY – Name of body part _____			
SPEECH/LANGUAGE TEST			
VISION TEST			
IQ TESTING			
EEG (BRAIN WAVE TEST)			
HIV TEST			
BLOOD TEST (HEMATOLOGY, CHEMISTRIES, RENAL FUNCTION, THYROID FUNCTION, ETC., NOT INCLUDING HIV)			
BREATHING TEST			
X-RAY – Name of body part _____			
MRI/CT SCAN – Name of Body part _____			

SECTION 7 – EDUCATION/TRAINING INFORMATION

A. CHECK THE HIGHEST GRADE OF SCHOOL COMPLETED.

Grade School

0	1	2	3	4	5	6	7	8	9	10	11	12	GED
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

College

0	1	2	3	4 or more
☐	☐	☐	☐	☐

B. DID YOU ATTEND SPECIAL EDUCATION CLASSES? ☐ **YES** ☐ **NO**

NAME OF SCHOOL _____

ADDRESS _____

(Number, Street, Apt. (If any), P.O. Box or Rural Route)

_____

City State Zip

DATES ATTENDED _____ **TO** _____

TYPES OF PROGRAM _____

C. HAVE YOU COMPLETED ANY TYPE OF SPECIAL JOB TRAINING, TRADE OR VOCATIONAL SCHOOL?

☐ **YES** ☐ **NO** **IF "YES" WHAT TYPE?** _____

APPROXIMATE DATE COMPLETED: _____

SECTION 8 – VOCATIONAL REHABILITATION, EMPLOYMENT, or OTHER SUPPORT SERVICES INFORMATION

ARE YOU PARTICIPATING IN ANY AVAILABLE REHABILITAITON PROGRAM OR ANOTHER PROGRAM OF VOCATIONAL REHABILITATION SERVICES, EMPLOYMENT SERVICES OR OTHER SUPPORT SERVICES TO HELP YOU GO TO WORK?

☐ **YES** (Complete the information below) ☐ **NO**

NAME OF ORGANIZATION _____

ADDRESS _____

(Number, Street, Apt. (If any), P.O. Box or Rural Route)

_____

City State Zip

DAYTIME PHONE NUMBER _____ _____

Area Code Number

DATES SEEN _____ TO _____

TYPES OF SERVICES OR TESTS PERFORMED _____

(IQ, vision, physicals, hearing, workshops, etc.)

SECTION 9 – REMARKS

Use this section for added information you did not show in earlier parts of the form. Please indicate the specific section you are providing additional information for (i.e. Section or Number and/or Title). When you are done with this section (or if you don't have anything to add), be sure to go to the next page and complete the blocks there.

SECTION 9 – REMARKS (Continuation)

NAME OF PERSON COMPLETING THIS FORM *(Please Print)*	**DATE FORM COMPLETED** *(Month, day, year)*
E-MAIL ADDRESS OF PERSON COMPLETING THIS FORM *(Optional)*	**MEDICAL LICENSE NUMBER:**

If the person completing this form is other than the disabled person or the person identified in Section 1. Item D., please complete the following information.

RELATIONSHIP TO DISABLED PERSON	**DAYTIME TELEPHONE NUMBER** ( ) -

ADDRESS *(Number and Street)* **City** **State** **ZIP**