MIDWEST OPERATING ENGINEERS WELFARE FUND

6150 Joliet Rd, Countryside, Illinois 60525-3994 Fax (708) 482-7687 Telephone (708) 482-7300

QUESTIONNAIRE FOR DEPENDENT HANDICAPPED CHILD

(Member Must Complete This Form)

Member Name____________________________________ UID_________________________________

Address____

____Phone________________________________

Handicapped Dependent (Full Name)____ Relationship To Member________________________________

Address (*if not same as member's*) ____

Dependent's Birth Date_______________________ Birth Place______________________________

Sex: Male - Female Age_____________ Weight__________ Height___________

1. Is dependent a resident in member's home 365 days per year? YES - NO

   If no, explain____

2. Has dependent ever been employed? YES - No If yes, give most recent date and type of employment____

   ____

3. Give history and details of dependent's mental and/or physical handicap.

   ____

   ____

4. Is dependent ambulatory? YES - NO
5. **ATTACH COPY** of dependent's Medicare card or Medicare Rejection Notice.
6. Are you, as parent, responsible for payment of dependent's medical expense?
   YES - NO If no, explain____

   Member must submit 1040 yearly indicating handicapped child is claimed as a dependent.

7. Give full name and complete address of any group or agency helping to meet medical expenses (i.e., Ester Seals, Muscular Dystrophy Foundation, Medicaid).

   ____

8. **ATTACH COPY** of most recent Social Security or Supplemental Security Income check. If no benefit available, attach copy of rejection notice.
9. Are you the sole means of dependent's support? YES - NO If no, explain.

   ____

10. Most recent date dependent consulted or was treated by physician.____________________________

11. **ATTACH REPORT OR LETTER** from dependent's personal physician giving physician's opinion of dependent's present health status and the prognosis.

____ _________________________

Member's Signature Date Completed

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DOCUMENTATION SHEET FOR HANDICAPPED ELIGIBLE DEPENDENT

(To be completed only by your Physician)

Member____**UID**__________________

Dependent____

Patient History:

Subjective Symptoms:

Objective Findings:

Dependent Intelligence Quotient (IQ) ______________________________

Diagnosis:

Treatment: List all dates of care for the past year and the diagnosis.

Prognosis:

Remarks: Explain in detail why this dependent will be unable to work at gainful employment, thus supporting himself/herself.

Does this dependent have any other health coverage? Yes - No If yes, explain.

____
Physician's Signature Date

____
Type Physician's Name

____
Physician's address

____
Physician's phone number