CalPERS

DISABLED DEPENDENT MEMBER QUESTIONNAIRE AND MEDICAL REPORT (HBD-34 Rev.04/23)

Health and/or Dental Benefits

Health Account Management Division
P.O. BOX 942715, Sacramento, CA 94229-2715
888 CalPERS (or **888**-225-7377) | TTY (877) 249-7442
FAX (800) 959-6545 | **www.calpers.ca.gov**

To determine a physical or mental health condition, illness, or disability and the right, if any, to health and/or dental benefits under the Public Employees' Medical and Hospital Act (PEMHCA), sections 599.500 (p), 599.501 (d), 599.501 (e), et seq.

All required documents and information must be submitted to CalPERS within 90 days prior to the dependent's certification or recertification date. Initial enrollment and certification of a disabled dependent provides an additional 60 days after the effective date to submit all required documents and information.

Member: Complete all information in Section A and the attached Authorization to Disclose Protected Health Information form and submit all documents to dependent's physician specializing in the dependent's disability.
Physician: A licensed physician specializing in the dependent's disability is required to complete all information in Section B and C and submit the form directly to CalPERS by fax or mail.

All items as noted above must be completed. Incomplete forms will not be accepted.

SECTION A: MEMBER AND DEPENDENT INFORMATION AND QUESTIONNAIRE

EMPLOYEE/ANNUITANT INFORMATION	DEPENDENT INFORMATION
NAME: _____	**NAME:** _____
Social Security Number (SSN): _____	**Social Security Number (SSN):** _____
ADDRESS:	**ADDRESS:**
PRIMARY PHONE NUMBER: _____	**DATE OF BIRTH:** _____

Provide the following information about the dependent who is seeking initial or continued enrollment and certification in the health and/or dental plan under the disabled dependent benefit. For purposes of this benefit, for a child to be eligible as a disabled dependent, the child must be 26 years old or older, and the following must be true: 1) The child is incapable of self-support because of a mental or physical condition and 2) the disability existed prior to the child reaching age 26 and continuously since age 26, as certified by a licensed physician specializing in the dependent's disability.

QUESTIONNAIRE			
1.	**Yes** ☐	**No** ☐	Is the dependent entitled to Medicare Part A (hospital care)? (If yes, attach a copy of the dependent's Medicare card.)
2.	**Yes** ☐	**No** ☐	Is the dependent entitled to Medicare Part B (medical care)? (If yes, attach a copy of the dependent's Medicare card.)
3.	**Yes** ☐	**No** ☐	Is the dependent incapable of self-support because of a physical or mental disability? If yes, what age did the dependent become physically or mentally disabled? _____

Certification:
I hereby certify under penalty of perjury, that information provided by me is true and correct to the best of my knowledge. I also agree to provide supporting documentation such as but not limit to, tax returns, state of financial liability, or any other documents, when requested by my employer or CalPERS.

_____ _____
Employee/Annuitant Signature Date

MEMBER NAME: _____ DEPENDENT NAME: _____

SSN: _____ SSN: _____

SECTION B: The **physician** specializing in the dependent's disability is to complete all the information in Part B and C and submit the form directly to CalPERS at the address or fax number listed at the top of the first page. All responses must be legible.

Dear Doctor:
The patient requests you to complete this **Medical Report** form. It will assist CalPERS in processing their claim for health/dental insurance as a disabled dependent under CalPERS benefit plan. By providing the medical information promptly, you will help the member and/or the patient to expedite the claims process.

	Medical Report
1.	I attended the patient for the current disabling medical problem or condition from _____to _____; at intervals of_____. I last examined the patient on_____.
2.	Medical History (related to disability): Date of Disability Onset:
3.	Diagnosis (REQUIRED): _____ ICD-10 Disease Code, Primary (Required): _____ ICD-10 Disease Code(s), Secondary: _____ DSM V Code(s) (if any): _____
4.	Objective Clinical Findings/Detailed Statement of Disability:
5.	Current Treatment(s) and /or Medication(s) (rendered to the patient for this disability): ☐ The patient is not currently receiving treatment(s) and/or medications for this disability. (Check if applicable.)
6.	Functional Assessment of Activities of Daily Living (ADL): Indicate the patient's physical and/or mental disability in the following ADLs that limit the patient's capacity for self-support. Check all that apply. **Mobility Skills** ☐ Walking ☐ Sitting ☐ Standing ☐ Lifting ☐ Bending **Self-Care Skills** ☐ Feeding ☐ Bathing ☐ Toileting ☐ Dressing **Sensory Skills** ☐ Hearing ☐ Seeing ☐ Speech ☐ Sensation **Cognitive Skills** ☐ Judgment ☐ Memory ☐ Planning/Follow Through ☐ Thinking/Processing Information
7.	Psychological / Psychiatric Assessment: List the specific psychological / psychiatric symptoms or behaviors, if any, that affect the patient's ADLs and limit their capacity to be self-supporting:

MEMBER NAME: _____ DEPENDENT NAME: _____

SSN: _____ SSN: _____

SECTION C: Medical Certification of Disability and Incapacity of Self-Support:

For purposes of this benefit, a child incapable of self-support can retain eligibility for CalPERS health benefits as a dependent (i.e., not capable of engaging in any substantial gainful activity) due to physical or mental disability which existed continuously prior to becoming 26 years of age.

Based upon your examination of the patient, please select only **one**:

☐ **A** The patient DOES NOT have a physically or mentally disabling injury, illness or condition that renders the patient incapable of self-support.

☐ **B** Medical Improvement Expected. The patient's current disability DOES render them incapable of self-support, but the disability is expected to resolve or improve sufficiently for the patient to be capable of self-support by _____.

PROJECTED DATE REQUIRED (mm/yyyy) (less than 3 years)

If the condition is likely to improve or resolve, estimate when this may occur.
Please DO NOT leave the PROJECTED DATE blank. Answers such as "indefinite" or "don't know" will not suffice.

☐ **C** Medical Improvement Possible. The patient's current disability DOES render them incapable of self-support. Improvement may occur but cannot be accurately predicted within a given period of time (recertification occurs in 3 years).

☐ **D** Medical Improvement Not Expected. The patient's current disability DOES render them incapable of self-support and the disability is NOT expected to improve. These are extremely severe impairments to be at least static but may be progressively disabling (recertification occurs in 7 years).

I certify that I am a licensed physician specializing in this dependent's disability and based upon my examination of the patient, the above statements truly describe the patient's disability and capability of self-support.

I am a _____
(Type of Physician) (Specialty)

licensed to practice by the State of _____.

PRINT, TYPE or STAMP PHYSICIAN'S NAME AS SHOWN ON LICENSE with ADDRESS, TELEPHONE AND FAX NUMBERS

_____ _____
PHYSICIAN'S NAME AS SHOWN ON LICENSE ORIGINAL SIGNATURE OF PHYSICIAN

_____ _____
LOCAL ADDRESS STATE LICENSE NUMBER

_____ _____
CITY, STATE, ZIP PHONE NUMBER

_____ _____
DATE FAX NUMBER

Privacy Notice

The privacy of personal information is of the utmost importance to CalPERS. The following information is provided to you in compliance with the Information Practices Act of 1977 and the Federal Privacy Act of 1974.

Information Purpose

The information requested is collected pursuant to the Government Code (sections 20000 et seq.) and will be used to conduct CalPERS Board of Administration duties under the Public Employees' Retirement Law, the Social Security Act, and/or the Public Employees' Medical and Hospital Care Act, as the case may be. Submission of the requested information is mandatory. Failure to submit the required information may result in CalPERS being unable to perform its functions regarding your status.

Please do not include information that is not requested.

Social Security Numbers

Social Security numbers are collected either on a mandatory or voluntary basis. If this is CalPERS' first request for disclosure of your Social Security number, then disclosure is mandatory. If your Social Security number has already been provided, disclosure is voluntary. Due to the use of Social Security numbers by other agencies for identification purposes, we may be unable to verify eligibility for benefits without the number.

Social Security numbers are used for the following purposes:

1. Enrollee identification
2. Payroll deduction/state contributions
3. Billing of contracting agencies for employee/employer contributions
4. Reports to CalPERS and other state agencies
5. Coordination of benefits among carriers
6. Resolving member appeals, complaints, or grievances with health plan carriers

Information Disclosure

Portions of this information may be transferred to other state agencies (such as your employer), physicians, and insurance carriers, but only in strict accordance with current statutes regarding confidentiality.

Your Rights

You have the right to review your membership files maintained by CalPERS. For questions about this notice, our Privacy Policy, or your rights, please write to:

CalPERS
CalPERS Privacy Officer
400 Q Street
Sacramento, CA 95811

You may also call us at **888 CalPERS** (or **888**-225-7377).