MACOMB COUNTY
Human Resources and Labor Relations Department
1 South Main Street, 6th Floor Mount Clemens, MI 48043 ▪ Phone (586)469-5280 ▪ Fax (586)469-6795

DISABILITY RETIREMENT INSTRUCTION SHEET

Below are the steps to follow in completing your disability application packet. There are three (3) forms to complete in this process: *Disability Retirement Application*, *Informed Consent and Authorization: Disability Retirement Application and Disability Retirement Physician's Statement*

Disability Retirement Application

1. You, the Macomb County Employee Retirement System (MCERS) member, must complete all five (5) sections
2. You may attach additional pages to fully explain your answers if needed. Be sure to sign all additional pages
3. Sign and date the form in section 5
4. Send the completed *Disability Retirement Application* form and any additional pages to MCERS using the address or fax number below

Informed Consent and Authorization: Disability Retirement Application

1. You must sign and date the bottom of this form
2. Make copies of the completed form and send a copy to MCERS and to each of your treating practitioners

Disability Retirement Physician's Statement

1. Make copies and give a copy of the entire *Disability Retirement Physician's Statement* to each of your treating practitioners. The cost associated with the completion of this form is not the responsibility of the Retirement System
2. These forms should be completed by each treating practitioner who has seen you in the last six (6) months
3. Your treating practitioners must include supporting documentation for such conditions as: musculoskeletal, cardiac, cancer, respiratory, neurological, diabetes, visual, auditory-vestibular, digestive, fibromyalgia
4. Your treating practitioners must send the completed Disability Retirement Physician's Statement and all supporting documentation to MCERS using the address or fax number below

Please send all completed portions of the packet to:

Human Resources and Labor Relations – Retirement Services
1 South Main Street, 6th Floor
Mt. Clemens, MI 48043

This information may also be faxed to MCERS at (586) 469-6795. If you have any questions, please contact Retirement Services at (586) 469-5113.

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DISABILITY RETIREMENT APPLICATION

The disability retirement application must have all sections completed before presenting to the Retirement Board for approval. Fully describe the medical problem, so the Medical Director can better assess your current disability status.

Section 1: Claimant Information

Employee Name (Last, First, Middle)		Social Security No. **XXX-XX-**	Employee ID
Street Address	City, State and Zip Code	Daytime Phone No. ( )	
Gender	Date of Birth		

Section 2: Employment Information

Date of Hire	Current Job Title
Currently Working? ☐ YES ☐ NO If No, last date worked _____	
Currently Receiving Worker's Compensation Benefits? ☐ YES If yes, when did you start receiving _____ ☐ NO	

Section 3: Medical Information

In your own words, describe your disabling medical conditions:

Section 4: Daily Activities Information

Do you have difficulty falling or staying asleep? ☐ YES ☐ NO
Do you take sleep aid medication to sleep? ☐ YES ☐ NO
If yes, what type and how often:
In what way(s) has your doctor told you to restrict your activities:

Do you have difficulty caring for your personal needs (e.g. grooming, dressing, cleaning, etc.) ☐ YES ☐ NO
If yes, please explain what personal needs cause difficulties:
Do you require any type of assistance with personal needs ☐ YES ☐ NO
If yes, please explain what personal needs require assistance:

Section 5: Member Acknowledgment

The undersigned member hereby makes claim to the Macomb County Employees' Retirement System for Disability Retirement and authorizes the submission of the physician's statement to the Medical Director of the Retirement System regarding his/her medical condition(s). The undersigned member agrees that the furnishing of this form or other forms supplemental thereto by the Retirement System is not to be considered nor does it constitute an admission of liability by the Retirement System. I hereby certify, under penalty of perjury, that the information submitted is true, correct and complete.

Dated this _____ day of _____ , 20_____ at _____ Michigan

Member Signature	
Witness Signature	Print Witness Name
Witness Street Address	Witness City, State and Zip Code

Section 6: HRLR – Retirement Services use only – DO NOT WRITE IN THIS SPACE

Is the member currently receiving Workers' Compensation benefits? ☐ YES ☐ NO		
Is the member currently receiving Long Term Disability? ☐ YES ☐ NO		
Member's County Credited Service	Member's Credited Service Purchased	Member's Total Credited Service
Signature of HRLR Verifier	Date Signed	

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INFORMED CONSENT AND AUTHORIZATION: DISABILITY RETIREMENT APPLICATION

Notice to Claimant

Your social security number, address, birth date, marital status, spouse information, and medical information are classified as private data. The Macomb County Employees' Retirement System (MCERS) will not share your private data with any person or agency except pursuant to MCERS' privacy policy or your Authorization below. If you do not provide the information requested by MCERS and its Medical Advisor, Managed Medical Review Organization, Inc. (MMRO), your application for a disability evaluation may be delayed.

A photocopy or facsimile of this Informed Consent and Authorization shall be valid as the original.

Authorization for MCERS and MMRO to release information

I give my informed consent and authorize MCERS and MMRO to provide information on my MCERS disability file to any independent medical examiners and/or consultants retained by MCERS or MMRO. The information may be used by my MCERS covered employer or former employer, an Administrative Law Judge or District/Circuit Court Judge, and the MCERS Retirement Board for the purpose of evaluating my disability application, and any appeals thereof. This authorization expires one year from the date of my signature or upon final determination of my eligibility for MCERS disability retirement benefits, whichever is later. I understand I may request a copy of this Authorization. This Authorization shall become effective on the date appearing next to my signature. I understand I have the right to revoke this Authorization at any time by notifying MCERS. I understand revoking this Authorization may delay the application process for disability retirement benefits.

HIPAA Authorization for care providers and consultants to release information to MCERS and MMRO

I hereby authorize the use and disclosure of protected health information about me as described below.

i. The following specific person/class of person/facility is authorized to disclose information about me to MCERS and MMRO: any health care provider, hospital, medical facility, rehabilitation consultant, or agency, or other organization.

ii. The following specific person/class of person/facility or entity may receive disclosure of protected health information about me: MCERS, MMRO and any independent medical examiners and consultants retained by MCERS or MMRO to assist in evaluation of my application for disability retirement benefits.

iii. The following information may be disclosed: all information with respect to any physical or mental condition and/or treatment of me, including information regarding AIDS/HIV infection, communicable diseases, alcohol and substance abuse and mental health.

iv. I may revoke this authorization by notifying MCERS in writing of my desire to revoke it. I understand any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

v. The purpose/use of the information is for my application for MCERS disability retirement benefits.

vi. This authorization expires one year from the date of my signature or upon the final determination of my eligibility for MCERS disability retirement benefits, whichever is later.

I have read, understand and I agree to both of the authorizations to release information.

Claimant Signature	Date

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DISABILITY RETIREMENT PHYSICIAN'S STATEMENT

The physician completes this form to describe the claimant's medical condition(s) that may qualify the claimant for a disability retirement benefit. Review and complete all sections of this form, including the appropriate checklist(s) on the Documentation Required to Substantiate Claims.

Section 1: Claimant Information

Employee Name (Last, First, Middle)		Social Security No. **XXX-XX-**	Employee ID
Street Address	City, State and Zip Code	Daytime Phone No. ( )	

Section 2: Physician Information

Name of practice	Physician's Name	Specialty
Street Address	City, State and Zip Code	Daytime Phone No. ( )

Section 3: Treatment Dates

Date the claimant became unable to work	Date of claimant's most recent visit	Date of first visit for this illness/injury
Frequency of visits	☐ Weekly ☐ Monthly ☐ Quarterly ☐ Other (specify) _____	

Section 4: Diagnosis and Treatment

If diagnosis is of one of the following areas: musculoskeletal, cardiac, cancer, respiratory, neurological, diabetes, visual, auditory-vestibular, digestive, fibromyalgia, please review the documentation required listed on the Documentation Required to Substantiate Claims.

Primary Disabling Condition	ICD Code
Secondary Disabling Condition	ICD Code
List Objective Findings	
Detail the extent to which the claimant's diagnosis affects the capacity to work	

Is the claimant currently taking medication for the primary or secondary conditions? ☐ YES ☐ NO
Describe any other treatment, including therapy
If claimant is being treated for "stress", please define "stress" as it applies to the claimant
Has the claimant been hospitalized for the primary or secondary condition? ☐ YES ☐ NO If yes, when?
Has the claimant had any surgical procedures as a result of the primary or secondary condition? ☐ YES ☐ NO If yes, provide procedure code
What is the claimant's condition status the past year? ☐ Improved ☐ Unchanged ☐ Worsened
What is the prognosis for recovery from the primary and/or secondary condition

Section 5: Attestation

Is my attestation the claimant's condition(s) renders them permanently unable to perform their own occupation? ☐ YES ☐ NO
I attest under penalty of perjury, under the laws of the State of Michigan, that the foregoing statements are true and correct to the best of my knowledge and belief. Dated this _____ day of _____ , 20_____ at _____ Michigan
Signature of Doctor

Please continue to Documentation Required to Substantiate Claims

Documentation Required to Substantiate Claims

If the disability retirement application is based on any of the conditions listed in this section, the following documentation/information is required where pertinent to the disability. Place a check by the type of condition reports, other reports, special tests, and laboratory or diagnostic studies that have been done and which support the diagnosis. Reports, tests and studies must be provided with the physician statement.

Musculoskeletal

- ☐ Report on any surgical treatment, including name of procedure and/or copy of operative note(s)
- ☐ Current comprehensive orthopedic examination
- ☐ Report on rheumatoid factor and sedimentation rate
- ☐ Report on uric acid relative to gouty arthritis
- ☐ Physical finding for all joints involved, including any deformities, tissue, and bone destruction, range of motion, and limitation of motion
- ☐ Current report or radiology reports of involved joints

Cardiac

- ☐ EKG and echocardiograms
- ☐ Report on exercise tolerance and stress
- ☐ Answers yes to one or more of the following questions:
  - ☐ Is the claimant able to climb one flight of steps or walk 200 yards on level ground?
  - ☐ Do such activities bring on severe dyspnea and/or angina?
  - ☐ What duration of physical activity can the claimant tolerate?
- ☐ Location of edema
- ☐ Report of any other physical findings

Cancer

- ☐ Report on the stage of cancer
- ☐ Treatment plan
- ☐ Oncology report
- ☐ CT scan
- ☐ Bone scans
- ☐ Lab results

Respiratory

- ☐ Frequency, duration, and severity of acute attacks of asthma, bronchitis, etc.
- ☐ Answer to the following question: Is the claimant able to climb a flight of stairs or walk 100 yards without dyspnea?
- ☐ Frequency of emergency room visits or hospitalization each year since diagnosed
- ☐ Report of current pulmonary function studies, including predicted and actual values, with the results expressed in CCs or liters and also in percentages. Include the oxygen and carbon dioxide level of room air.

Neurological

- ☐ Current comprehensive neurological examination dated within the last six months
- ☐ If the condition is a seizure disorder, give the frequency and severity of the seizures in the past year
- ☐ Report on any of the following conditions which are present, indicating severity, distribution, and residual function in affected parts: atrophy, paralysis, hemiplegia, impaired speech, tremors, reflexes, and mental disturbances (including a report on cognitive ability)

Diabetes

- ☐ Symptoms and complications
- ☐ History including onset date, length of treatment, and weight loss
- ☐ Current treatment, including insulin and medications
- ☐ Report on current blood sugars with date and/or A1C
- ☐ Report on current urinalysis with date

Visual

- ☐ Report on visual acuity after best correction: R 20/ and L 20/
- ☐ Report of visual fields, including chart, if indicated
- ☐ Report on funduscopic findings
- ☐ Description of ocular tension
- ☐ Description of therapy and prognosis
- ☐ Information about whether or not the claimant drives an automobile

Auditory-Vestibular

- ☐ MRI or CT reports
- ☐ Audiogram with respect to puretone, SRT, and speech discrimination
- ☐ If claimant has hearing aids, indicate the thresholds with respect to SRT and speech discrimination
- ☐ Reports on vertigo or Menieres disease, including the following:
  - Frequency, duration, and severity of attacks
  - ENG report
  - Report on vestibular function and gait
  - Report of any medical and surgical treatment

Digestive

- ☐ Report on symptoms and treatment
- ☐ Endoscopies, radiological reports, and special studies
- ☐ Complete report of current lower or upper GI series with date, if pertinent

Fibromyalgia

- ☐ Report of any tender points
- ☐ A functional capacity evaluation for the claimant's job
- ☐ Psychiatric report (if applicable)