NEW YORK STATE OF OPPORTUNITY. | Office of Mental Health

REQUEST FOR DISABILITY DETERMINATION

Name of Youth: _____

Date of Birth: _____

This is to request that the Office of Mental Health (OMH) determine whether the above-named youth is disabled for the purposes of the Medical Assistance Program, as designated by the Department of Social Services.

I authorize OMH to review and evaluate any mental health, health or educational information it has received to assess whether the above-named youth is disabled. I also authorize OMH to request clarification or obtain additional documentation necessary to confirm or verify this information to determine whether he/she is disabled.

I understand that this form is not an application or reapplication for Medical Assistance benefits, and that OMH will be determining whether the above-named youth is disabled but not whether he/she is eligible for Medical Assistance.

_____
Signature of Parent/Legal Guardian

_____
Relationship

_____
Date Signed

Revised 06/2020