Thompson

October 18, 1956

Honorable Edward J. Patten
Secretary of State
State House
Trenton, New Jersey

Dear Secretary Patten:

Enclosed herewith for filing is the following regulation of the Bureau of Assistance of the Division of Welfare of this Department:

County Series No. 3

Revised forms ODA-2D, Parts I, II, Examining Physician's Report, and ODA-2D, Part III, Social Data Summary

Very truly yours,

DEPARTMENT OF INSTITUTIONS AND AGENCIES

John W. Tramburg

JWT:4

John W. Tramburg, Commissioner

CC: Mr. Brendan T. Bryne, Secretary to the Governor
Mr. Elmer V. Andrews, Director, Division of Welfare
Mrs. Elizabeth Feehan, Assistant to the Commissioner

Trenton

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John W. Trenbur[illegible], Commissioner

JWT:A

RECEIVED
STATE OF NEW JERSEY
OFFICE OF
CHIEF EXECUTIVE
OCT 23 2 46 PM '56

CC: Mr. Brendan T. Byrne, Secretary to the Governor
Mr. Elmer V. Andrews, Director, Division of Welfare
Mrs. Elizabeth Feehan, Assistant to the Commissioner

State of New Jersey
Department of Institutions and Agencies
Division of Welfare

BUREAU OF ASSISTANCE

REGULATION # _____
County Series No. 3

ISSUED: 2/15/52 (Date)

REV.: _____ (Date)

TITLE: Disability Assistance - Temp. Instructions

SUBJECT: _____

STATUTORY REFERENCE: R.S. 44:7-6

Attached are revised forms ODA-2D, Parts I, II, Examining Physician's Report, and ODA-2D, Part III, Social Data Summary

[Previously issued without date and inserted as Attachment #2, but not so marked on the forms.]

_____, Chief
Bureau of Assistance

Approved:
By: John V. Tramburg

STATE OF NEW JERSEY
DEPARTMENT OF INSTITUTIONS AND AGENCIES
DIVISION OF WELFARE—BUREAU OF ASSISTANCE

Dr. ..... Date .....

EXAMINING PHYSICIAN'S BILL

FOR MEDICAL REPORT ON PERMANENT AND TOTAL DISABILITY

..... County Welfare Board, ...
(address)

Name of Patient ..... Reg. No. .....

Address ..... Age ..... Sex .....

For examination of patient and preparation of the attached report, as per authorized allowances:

Date	(Check)		
.....	☐	Examination at office	$5.00
.....	☐	Examination at hospital	5.00
.....	☐	Examination at patient's home	7.50
.....	☐	Examination in public institution	No fee
.....	☐	Other (explain)	

Approved for Payment by Review Team No.....

Date ..... Signature .....

NAME OF PHYSICIAN .....
(Print or type as name should appear on check)

SIGNATURE .....

ADDRESS .....

NOTICE TO EXAMINING PHYSICIAN

(Please read carefully — Complete all sections including negative answers where applicable)

The patient named above has applied to the County Welfare Board for Disability Assistance and has designated you as the physician of his choice to make the medical examination and report required to support his application.

The information requested in the attached report is necessary in order for this agency to reach a decision as to whether the patient is PERMANENTLY AND TOTALLY DISABLED, as defined below, for purposes of granting public financial assistance.

> A permanently and totally disabled person shall mean a needy person who, by reason of a PERMANENT physical or mental defect, disease or impairment, (other than blindness) is disabled to the degree that prevents him from performing the essential elements of a useful occupation, existent in the community, and within his competence. ("Useful occupation" includes home making.)

A presumption is made that any person presenting this "Examining Physician's Report" to you has some DEFECT, DISEASE OR IMPAIRMENT. The preparation of this report shall be based on a complete medical and physical EVALUATION of the patient. If the patient has been under your care recently, the report may be prepared on the basis of your cumulative knowledge and clinical records WITHOUT A NEW EXAMINATION. However, if you have not personally examined the patient within three months, a new examination is requested. You MUST (in order to receive payment for your service) complete ALL SECTIONS OR PARAGRAPHS including negative answers where applicable. The medical evidence submitted must be ADEQUATE TO SUBSTANTIATE OBJECTIVELY your diagnosis and the degree of permanence in such a manner that a reviewing physician would reasonably accept your diagnosis or your identification of the defect, disease or impairment, without examining the patient. It should be understood that although a diagnosis is desired, it may not be known because of insufficient data. In such cases, PRESENT A FULL PICTURE OF THE DEFECT, DISEASE OR IMPAIRMENT. OPINIONS without objective evidence WILL NOT BE ACCEPTED.

We urge you to furnish the informatioin as PROMPTLY AS POSSIBLE to avoid delay in reaching a decision about the eligibility of the patient. This information will be held CONFIDENTIAL within the agency, and the patient will be referred to you for any information he wants concerning the contents of this report, except in the event of a fair hearing (appeal procedure) when the evidence will have to be made available to the appellant.

Please mail this report to the agency in the attached self-addressed post-paid envelope. DO NOT HAND IT TO THE PATIENT FOR DELIVERY. Your fee for service, when billed on the upper portion of this sheet, will be paid promptly when the Medical Review Team DETERMINES THAT YOUR REPORT IS COMPLETE.

OFFICIAL CRITERIA
FOR CLASSIFICATION OF
CARDIAC DISEASE AND MUSCULOSKELETAL DISABILITY

AMERICAN HEART ASSOCIATION ESTIMATE OF FUNCTIONAL OR WORK CAPACITY.

This index is largely derived by inference from the history and patient's symptoms on effort. Physical signs, roentgenograms, electrocardiogram and judgment of prognosis have no bearing in determining this index.

Class I	Patients with cardiac disease and no limitation of physical activity. Ordinary physical activity causes no discomfort. There are no symptoms of cardiac insufficiency, nor do they experience anginal pain.
Class II	Patients with cardiac disease and slight limitation of physical activity. They are comfortable at rest. If ordinary physical activity is undertaken, discomfort results in the form of undue fatigue, palpitation, dyspnea or anginal pain.
Class III	Patients with cardiac disease and marked limitation of physical activity. They are comfortable at rest. Discomfort in the form of undue fatique, palpitation, dyspnea or anginal pain, is caused by less than ordinary physical activity.
Class IV	Patients with cardiac disease who are unable to carry on any physical activity without discomfort. Symptoms of cardiac insufficiency or of the anginal syndrome are present, even at rest. If any physical activity is undertaken discomfort is increased.

FUNCTIONAL CLASSIFICATION OF MUSCULOSKELETAL INADEQUACY OR FAILURE.

(Criteria adopted by American Rheumatism Association)

Class I	Complete functional capacity with ability to carry on all usual duties without handicaps.
Class II	Functional capacity adequate to conduct normal activities despite handicap of discomfort or limited mobility of one or more joints.
Class III	Functional capacity adequate to perform only little or none of the duties of usual occupation or of self care.
Class IV	Largely or wholly incapacitated with patient bedridden or confined to wheel-chair, permitting little or no self care.

STATE OF NEW JERSEY

DEPARTMENT OF INSTITUTIONS AND AGENCIES

DIVISION OF WELFARE — BUREAU OF ASSISTANCE

Dr. ..... Date .....

EXAMINING PHYSICIAN'S REPORT

FOR DETERMINATION OF PERMANENT AND TOTAL DISABILITY

..... County Welfare Board, ...
(address)

Name of Patient ..... Reg. No. .....

Address ..... Age ..... Sex .....

ALL SECTIONS OF THIS EXAMINATION MUST BE FULLY COMPLETED INCLUDING NEGATIVE ANSWERS WHERE APPROPRIATE

HEIGHT (without shoes) ..... WEIGHT (without clothing) .....
(if patient is not ambulatory, omit above)

A. GENERAL OBSERVATIONS:

1. Note evidence of pallor, cyanosis, pigmentation, ulcers, scars, decubitus, skin lesions, draining sinuses, etc. If present, state location, cause and diagnosis if known.

.....

.....

2. Record any swellings, hernia, organ (liver or spleen) or glandular enlargement, tumor or cancer. If present describe as to location, size, number, consistency, discreteness, cause and diagnosis if known.

.....

.....

3. Is there incontinence of bladder? ..... Bowels? ..... If so, state cause and diagnosis, if known.

.....

.....

4. Note evidence of malnutrition and make any appropriate remarks or recommendations.

.....

.....

B. SPECIAL SENSES:

Record any objective signs of a defect, disease, impairment, or pathology relating to Eyes, Ears, Nose, Throat, Speech. If present, describe, give cause and diagnosis if known:

.....

.....

C. CARDIO-VASCULAR-RESPIRATORY SYSTEMS:

Blood Pressure ..... Pulse Rate ..... Regular or Irregular .....
Rate at apex of heart..... Can dorsalis pedis.....and posterior tibial arteries be palpated?.....
Is there dyspnea on effort?..... Record nature of any defect, disease, impairment or pathology relating to above systems including physical, laboratory, X-ray and other diagnostic findings, if available, upon which your diagnosis is based. If a diagnosis of cardiac disease is made, include an estimate of functional or work capacity according to standards set by American Heart Association. (See Part 1, Page 2 for information).

.....

.....

D. MUSCULOSKELETAL EVALUATION:

Is there an absence of any extremity?..... Is there a defect, deformity, or impairment, relating to neck, back, or any extermity?..... If so, describe in detail the extent, muscle weakness and limitation of joint range of motion of involved parts, and classify the patient functionally according to criteria adopted by the American Rheumatism Association. (See Part 1. Page 2 for information.)

.....

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E. NEUROLOGICAL EVALUATION:

1. Is there a history of convulsions?..... If so, describe character and frequency, duration of history of attacks, whether controlled by drugs, cause and diagnosis of convulsions, if known.

.....

.....

.....

2. Does patient have a muscle weakness or paralysis? ..... If so, state part of body involved, type (flaccid, spastic, etc.), note any pathological reflexes, evidence of clonus, involved nerves (if known), cause and diagnosis if known.

.....

.....

.....

3. Does patient have a sensory deficit of any part of the body? ..... If so, state sensory level (if any), deficiency in perceiving or appreciating sensations (i.e., touch, pin-prick, pain, temperature, position sense, vibratory sense.) Record part of body having above deficit, cause and diagnosis, if known.

.....

.....

.....

4. Is there any atrophy .....; or hypertrophy ..... of skeletal muscle? If so, state location, cause and diagnosis, if known.

.....

.....

.....

F. PSYCHIATRIC EVALUATION:

1. Is patient disoriented? ..... Has he lost control of any of his mental faculties? ..... If "yes", explain.

.....

.....

2. Does patient suffer from an obvious mental or emotional disturbance, psychosis, mental retardation, etc.? ..... If "yes", explain in detail and cite psychiatric opinion and/or psychological test results, if any, supporting such opinion.

.....

.....

3. Does patient in your opinion have sufficient mental ability, judgment or competence to make decisions concerning his well being, including the handling of money? Yes ..... No ..... If "no" explain.

.....

.....

G. PERTINENT DIAGNOSTIC AIDS:

(List and cite the results of any significant and pertinent laboratory or diagnostic studies which you possess or to which you have had access in making this evaluation. DO NOT HAVE ANY LABORATORY TESTS MADE AT OUR EXPENSE WITHOUT FIRST SECURING OUR APPROVAL.)

.....

.....

.....

H. PROSTHESES AND APPLIANCES:

1. List those prostheses and appliances patient now possesses. (Include artificial limbs, braces crutches, canes, hearing aid, special shoes, wheelchair, etc.)

.....

2. List those you feel might assist patient in his daily activities at home or on the job.

.....

3. DO YOU THINK FUNCTION COULD BE IMPROVED OR PATIENT'S CONDITION CORRECTED OR CONTROLLED BY MEDICAL, SURGICAL, OR REHABILITATIVE PROCEDURES? Specify if possible.

.....

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.....

.....

(See reverse side of this sheet for further items to be completed)

I. MEDICAL SUMMARY:

1. Major Diagnosis .....
2. Date of onset .....
3. Minor Diagnosis (if any) .....
.....
4. Cause of major defect, disease or impairment: (Check whichever is applicable)
   a. Congenital .....
   b. Disease .....
   c. Injury or accident (due to employment) .....
   d. Injury or accident (not connected with employment) .....
   e. Other .....
5. CHARACTERISTICS OF MAJOR DISABILITY: Static (stable) ..... Progressive .....
   Improving .....
6. DEGREE OF INCAPACITY: Bedridden ..... Ambulatory ..... If ambulatory indicate: only with wheelchair ..... brace ..... crutches ..... cane ..... prosthesis ..... other (specify) .....
7. RECOMMENDATIONS: Indicate any special examination, diagnostic aid, consultation with a specialist, etc., you would advise for completion of diagnosis or evaluation of defect, disease or impairment.

.....
.....
.....
8. Have you seen patient before this examination? .....
9. Is patient under your continued care?..... At office .....; clinic .....; home .....
10. How frequent? ..... Is this sufficient? .....
11. Is patient now receiving any medication or treatment? (If so, give details, as name of drugs, dosage, duration, etc.) .....
.....
.....

J. In your opinion could this individual work full-time in the type of occupation or job (including homemaking) he formerly held? Yes____ No____ If "no", answer the following:

Could individual work part-time in formed occupation? Yes..... No.....

Could individual work full or part-time in any other type of occupation (including homemaking)? Yes..... No..... If "yes", answer following:

What other type of occupation do you recommend for this individual? .....
.....Full-time ☐ Part-time ☐

Additional comments or remarks (including any opinion you may have as to this patient's physical or mental ability to engage full-time in any useful employment, or to carry on normal responsibilities of homemaking on a regular and predictable basis.)

.....
.....
.....

K. I hereby certify that these statements are based on current or past examinations of the patient, and that they are true to my best knowledge, information and belief.

Date ..... Signature of Physician .....
(Indicate whether M.D. D.O. etc.)

N. J. Certificate No.....

STATE OF NEW JERSEY
DEPARTMENT OF INSTITUTIONS AND AGENCIES
DIVISION OF WELFARE—BUREAU OF ASSISTANCE

Form ODA-2D Part III
Page 1 of 4 pages
Rev. 7/56

SOCIAL DATA SUMMARY

..... County Welfare Board Registration No. .....

Client ..... Sex: (Circle) M F
(Last Name) (First) (Middle)

Address ..... Marital Status: (Circle) S M W D Sep.

Birthdate ..... Birthplace .....
(Day) (Month) (Year)

1. SHELTER ARRANGEMENTS: (Refer to instructions before completing.)

Check Present	Check Future		
☐	☐	1)	Private General Hospital (Identify) .....
☐	☐	2)	Public General Hospital (Identify) .....
☐	☐	3)	Public Medical Institution, Chronic (Identify) .....
☐	☐	4)	Licensed Nursing Home (Identify) .....
☐	☐	5)	Incorporated or Charitable Home (Identify) .....
			☐ Medical ☐ Domiciliary
☐	☐	6)	Boarding Home
☐	☐	7)	Rooming House
☐	☐	8)	Housekeeping Room(s)
☐	☐	9)	Apartment
☐	☐	10)	House

a)

b) If shelter arrangement is checked as 6), 7), 8), 9), or 10) refer to "Instructions", Attachment No. 3, before entering following data:

1) Persons in home .....

.....

.....

2) Describe shelter arrangement, giving type of dwelling, number of rooms, etc.:

.....

.....

.....

.....

.....

.....

3) Utilities and Facilities:

Lights ..... Cooking .....

Heat .....

Water ..... Laundry .....

Bath & Toilet .....

Stairs ..... Elevator service? .....

4) Describe deficiencies, if any, in housing standards .....

.....

.....

5) Describe deficiencies, if any, in housekeeping standards .....

.....

.....

2. ECONOMIC STATUS:

a) Public Assistance received prior to application (Give program, dates, current grant)

.....

.....

b) Assistance from private agencies prior to application (Give agency and dates) .....

.....

c) Other source of support prior to application if not employed .....

.....

d) Current Income: None ..... Source ..... Amount $.....

e) If any other current method of partial maintenance, explain .....

.....

3. EDUCATION:

a) Literacy in English (Answer Yes or No for each): Speak? ..... Read? ..... Write? .....

b) Can client speak, read or write other languages? (Specify) .....

.....

c) Highest grade completed: (Circle) 0 1 2 3 4 5 6 7 8; H.S. 9 10 11 12; College 1 2 3 4

Give special or major study .....

d) Other training: .....

e) Special skills or hobbies: .....

4. EMPLOYMENT HISTORY:

a) Soc. Sec. Acct. No. ..... None ( ); b) Ever in paid employment? Yes ( ); No ( ).

c) Normal occupation: ( ) Homemaker ( ) Paid domestic

( ) Self-employed ( ) Farming ( ) Non-farming ..... (Specify)

( ) Wage or Salary Earner: ( ) Farming ( ) Non-farming ..... (Specify)

( ) Other .....

d) List all employments starting with most recent job. (Include self-employment)

TITLE OR TYPE OF WORK	FULL OR PART TIME	DATES	HIGHEST WEEKLY WAGE RATE	REASONS FOR LEAVING

e) Name and address of last employer: .....

Nature of employer's business: .....

[NOTE: ITEM f) MAY BE OMMITTED ON OLD AGE ASSISTANCE APPLICATIONS]

f) If employed in 6 months period prior to application, give following details on last week of employment:

Number of hours worked .....

Gross earnings $.....

Place: Home ( ); Other ( ).

Kind of employment: (describe)

Self employment .....

Sheltered .....

Other .....

5. PERTINENT MEDICAL HISTORY: Enter only verified information and state how obtained (letter, interview, telephone). Attach any written summary of diagnosis and treatment or abstract of medical record obtained.

a) Hospitalization (in-patient care)

Hospital	Method of Verification	Dates of Admission and Discharge	Hospital Discharge Diagnosis

b) Clinic (out-patient care)

Clinic	Method of Verification	Dates under care	Clinic Diagnosis
		From ..... to	
		From ..... to	
		From ..... to	
		From ..... to	

c) Other Institutional Care

Institution	Method of Verification	Dates of Admission and Discharge	Institutional Discharge Diagnosis

d) Physician's Service (Private)

Name	Source of Information	Dates under care	Diagnosis
		From ..... to	
		From ..... to	
		From ..... to	

e) Other (Specify .....

.....

REGISTRATION NO. .....

6. EXTENT OF ACTIVITY; HELP FROM OTHERS:

a) Check whichever one of the following most nearly describes the usual area limitation of client's activity:

( ) Bed-fast ( ) Chair-fast ( ) Room-bound
( ) House-bound ( ) Limited to house and grounds ( ) Neighborhood

b) Answer each of the following questions by checking whichever of the alternates is most accurate:

1) Does client go from bed to chair unassisted? ( ) Yes; ( ) No. Go to toilet unassisted? ( ) Yes; ( ) No.
2) Put on mechanical aid or prosthetic appliance unassisted? ( ) Yes; ( ) No; ( ) Not required.
3) Use stairs alone? ( ) Yes; ( ) No. Require handrail? ( ) Yes; ( ) No.
4) Does client go into the community unaccompanied? ( ) Yes; ( ) No. Accompanied? ( ) Yes; ( ) No.
5) Does client perform any homemaker duties? ( ) Yes; ( ) No. If "Yes" describe:

.....

.....

.....

c) Check which of the following services are provided to the client by the sources indicated and describe extent and frequency of service:

SOURCE	FEEDING	BATHING	TOILET ACTIVITIES	DRESSING	MEDICATION	INJECTION	NONE
Immediate Family:	( )	( )	( )	( )	( )	( )	( )
Describe							
Neighbors or Relatives	( )	( )	( )	( )	( )	( )	( )
Describe							
Boarding, Nursing Home or Institutional Staff:	( )	( )	( )	( )	( )	( )	( )
Describe							
Visiting Nurse:	( )	( )	( )	( )	( )	( )	( )
Describe							

.....

.....

d) Identify any other service given to client and describe:

.....

.....

7. SOCIAL EVALUATION: Give factual description of client's appearance, behavior, attitudes, personality, and significant comments which in your opinion would assist in understanding client's situation and the nature and extent of the client's disability. If you believe there is question as to whether or not a Disability Assistance client is a "homemaker", prepare and attach one copy of a Homemaker Questionnaire to material submitted to Bureau.....

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8. REHABILITITION SERVICE: If applicant has ever been referred to or treated by any of the following indicate:

a) (1) State Rehabilitation Commission, date .....

(2) Bureau of Crippled Children, date .....

(3) Rehabilitation Division, Veterans Administration, date .....

(4) Voluntary or private rehabilitation agency, date

(Specify) .....

b) Disposition: (List disposition by all agencies using appropriate identifying number)

IDENTIFYING NUMBER	ACCEPTED OR REJECTED	IF REJECTED, GIVE REASON: IF ACCEPTED, DESCRIBE SERVICE FURNISHED. STATE WHETHER STILL ACTIVE, OR DATE AND REASON FOR CLOSING

9. ADDITIONAL SOCIAL DATA:

a) Marriage and Divorce Records (in order)

DATE	MARRIED OR DIVORCED	PLACE	FULL NAME OF SPOUSE

b) Maiden name, alternate spelling, etc. (Explain any entry.) .....

c) Father's Name ..... Birthplace .....

Mother's Name ..... Birthplace .....

d) Previous applications for categorical assistance:

COUNTY AND STATE	DATE	CATEGORY	DISPOSITION

e) Record of Social Service Exchange Clearance:

.....

.....

.....

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.....

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DATE..... .....

Signature of Case Worker