Disability Income / Work Support: OSS Disability Intake Form

Instructions.

1. Pay the fee for each disability form(s).
2. Hand in the disability form (you must complete your section) or make sure you have included the EDD receipt number
3. Fill out this form, OSS Disability Intake Form.

Today's Date _____

Please Fill Out To Get Started

Patient Name_____ Date of Birth_____ Phone _____

EDD Receipt Number_____ Last 4 digits of your SS# _____ Your Email _____

Only for EDD. Look for a number that start with R10000XXXXXXXXX Only for EDD.

Your Provider at OSS

- ☐ Stephan Yacoubian, MD
- ☐ Raymond Raven, MD
- ☐ Shahan Yacoubian, MD
- ☐ Yuri Falkinstein, MD
- ☐ Mark Mikhael, MD
- ☐ Vaz Galstjan, PA-C
- ☐ Omar Duenes, PA-C
- ☐ Angelo Smith, PA-C
- ☐ Katie Wong, PA-C
- ☐ Richard Feldman, MD
- ☐ Jeffrey Korchek, MD

Please pick 1. I am requesting disability because my condition:

- ☐ Requires surgery. If yes, date of expected surgery _____
- ☐ Was caused by a sudden injury or accident. Date of Injury: _____
  - ☐ No, NOT related to work. ☐ Yes, injury was during work.
- ☐ Is pain that grew over time or when I stopped walking. Approximate date started: _____

Please provide these dates:

Last Date **I Worked** _____ **1st Date of Treatment** for Issue with OSS Provider _____

Most recent date I came to OSS to treat this specific issue _____ **Date my disability** began _____

Might be different than last date worked.

Please pick 1. Once OSS completes form, I want to:

- ☐ Pick up at office
- ☐ Have OSS mail directly to insurer / agency
- ☐ Have OSS email to me and then I will mail (Fastest! Most Reliable) Not Applicable for EDD.

You are Done!

What to expect next?

1. **Wait for OSS to do its part.** It will take OSS - the disability coordinator - **2 weeks** (10 business days) to complete.
2. **Want status?** Email us 10 days after submitting.

OSS will fill out the section below

Name of Disability Insurance(s) _____

Name of OSS Staff Member Accepting Income / Job Protection Disability Form & Date _____

Following Must be Complete To Hand Off to Disability Coordinator:

- ☐ Paid Fee Total Paid: _____
  - ☐ EDD ($25) ☐ FMLA ($35) ☐ Private ($35)
- ☐ Completed this form
- ☐ Completed Agency Disability Form, Patient Section

Name of Disability Coordinator:

- ☐ Missy
- ☐ Jose
- ☐ Vanessa
- ☐ _____

Disclaimer: Orthopaedic Surgery Specialists is the registered business official name of OSS.