

Client Name:

## ACKNOWLEDGEMENT OF CBEST PROGRAM & NEED FOR MEDICAL EVIDENCE

Thank you for completing the CBEST intake process. All disability applications require current medical and mental health treatment records. The next step is to evaluate your current medical records to determine if you are eligible for CBEST.

\_\_\_\_ I understand that CBEST has not applied for disability benefits on my behalf as of today's date but is conducting an intake to determine eligibility for the CBEST Program.

\_\_\_\_ I understand that disability applications require medical evidence.

\_\_\_\_ I understand that my medical records are being evaluated for my ability to work a full-time job.

\_\_\_\_ I understand that my current medical records are being evaluated by Los Angeles County Department of Health Services and Department of Mental Health and that they will determine eligibility for CBEST.

\_\_\_\_ I understand that if I don't have sufficient medical evidence, that I will have one of the following options:

- I will be encouraged and assisted with enrollment in primary or specialty health care.
- I will be encouraged and assisted with enrollment in mental health care (4-6 months).
- I will be encouraged and assisted with enrollment in substance use treatment (3-4 months).
- I may not be eligible for CBEST based on my condition(s), but understand that I can apply for SSI on my own.
- I can refuse to participate in treatment, but this will make me ineligible for CBEST.

\_\_\_\_ I understand that ongoing treatment will be necessary in order to demonstrate my level of impairment BEFORE an SSI application is completed.

\_\_\_\_ I understand that if CBEST determines my impairment does not demonstrate a severe disability after reviewing all treatment records, I am encouraged to return to CBEST should my conditions significantly worsen or I present with a new impairment(s).

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Client Signature

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Date

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Intake Worker Name