



## Supplemental Answers for Full Application

Valid beginning October 1, 2009

Complete this form only if you need additional space to answer any of the following questions on your application. For assistance, call **1-800-LTC-FEDS** (1-800-582-3337) (TTY 1-800-843-3557).

**Name**

\_\_\_\_\_  
First M.I. Last

Home phone \_\_\_\_\_ Social Security number \_\_\_\_\_ Date of birth \_\_\_\_\_  
Month / Day / Year

This form is part of the application I signed on \_\_\_\_\_  
Month Day Year

Signature \_\_\_\_\_ Date \_\_\_\_\_  
Month Day Year

**Part C, Questions 1–5:** If the answer to any of questions 1–5 is “YES,” explain below.

Name, address, and phone number of treating health professional	Question number	Diagnosis or disorder	Date of onset (mm/yy)	Date of last treatment (mm/yy)
Name _____ Address _____ Phone _____				
Name _____ Address _____ Phone _____				
Name _____ Address _____ Phone _____				

**Part C, Question 6:** Medications: List all prescription medications taken over the past 6 months.

Name, address, and phone number of treating health professional	Name of medication Check box if taking currently	Dosage (e.g., 10 mg)	Frequency (e.g., 2 x a day)	Reason prescribed
Name _____ Address _____ Phone _____	<input type="checkbox"/>			
Name _____ Address _____ Phone _____	<input type="checkbox"/>			
Name _____ Address _____ Phone _____	<input type="checkbox"/>			
Name _____ Address _____ Phone _____	<input type="checkbox"/>			

You may use as many additional forms as you need to provide your complete information. Attach completed forms to your application.