DD-1104

11/16

**DISABILITY DETERMINATION REQUEST – MEDICAL ASSISTANCE CASE**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **I. IDENTIFYING INFORMATION: To be completed by KDHE** | | | | | | | | | | | | | | | | | | | | | |
| A. Name (Last, First, Middle) | | | | | | | | | | | | | | B. DOB | | | | | | C. SSN | |
|  | | | | | | | | | | | | | |  | | | | | |  | |
| D. Address (Street, City, Zip) | | | | | | | | | | | | | | | | | | | | E. Telephone No. | |
|  | | | | | | | | | | | | | | | | | | | |  | |
| F. Education | | | G. Sex | | | | | H. Race | I. Customary Occupation | | | | | | | | | | | | |
|  | | |  | | | | |  |  | | | | | | | | | | | | |
| J. Currently Employed | | | | | | | | K. Approximate Monthly Income | | | | | | | | | | | L. Case No. | | |
|  |  | No | |  | | Yes | |  | | | | | | | | | | |  | | |
| **II. REFERRAL INFORMATION: To be completed by KDHE** | | | | | | | | | | | | | | | | | | | | | |
| A. Application Date | | | B. Social Security Denial  Date Reason Verification | | | | | | | | | | | | | | C. Onset Date Requested | | | | |
|  | | |  | | | |  | | | | |  | | | | |  | | | | |
| D. Reconsideration | | | | | | | | | | | E. KDHE Worker Name | | | | | | | | F. Phone | | |
|  |  | No | |  | Yes, date | | | | | |  | | | | | | | |  | | |
| G. Office/Address | | | | | | | | | | | | | | | | | | | H. E-Mail | | |
|  | | | | | | | | | | | | | | | | | | |  | | |
| I. Signature of KDHE Worker | | | | | | | | | | | | | | | | | | | J. Date | | |
|  | | | | | | | | | | | | | | | | | | |  | | |
| **III. DISABILITY DETERMINATION INFORMATION: To Be Completed by DDS** | | | | | | | | | | | | | | | | | | | | | |
| A. Allowed | | | B. Denied | | | | | C. Continued | | | | D. Ceased | | | | | | E. Onset Date | | | |
|  | | |  | | | | |  | | | |  | | | | | |  | | | |
| F. Diagnosis | | |  | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| G. Basis For Determination, Treatment, Recommendations, and/or Remarks | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| **IV. REFERRAL AND/OR RECOMMENDATION INFORMATION** | | | | | | | | | | | | | | | | | | | | | |
| A. Vocational Rehabilitation Referral | | | | | | | | | |  | Yes |  | No | |  | Date | | |  | | |
| B. Recommended Medical Re-examination | | | | | | | | | |  | Yes |  | No | |  | Date | | |  | | |
| C. Blind Services Recommended | | | | | | | | | |  | Yes |  | No | |  | Date | | |  | | |
| Signature (Disability Examiner) | | | | | | | | | | Date | | Signature (Medical Consultant ) | | | | | | | | | Date |
|  | | | | | | | | | |  | |  | | | | | | | | |  |