DD-1104

11/16

**DISABILITY DETERMINATION REQUEST – MEDICAL ASSISTANCE CASE**

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| --- |
| **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 DenialDate 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 |
|  |  |  |  |