**DISABILITY DETERMINATION DATA/REPORT**

DD-1105

11-16

**Medical Assistance Case**

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| **I. SOCIAL INFORMATION** |
| Give social information based on applicant's statements, social worker's observations, and case narrative. Please be as specific as possible. |
| A. Disabling condition or conditions: Describe, including cause, duration, response to treatment, etc. |
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|  |
| B. Effect of applicant's disability: Describe in terms of: |
| 1. Mobility and limitation of ordinary physical activities: |
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|  |
|  |
| 2. Dependence on others for help or service: |
|  |
|  |
|  |
| 3. Appliances or prostheses necessary (for example: hearing aid, crutches, artificial limb, etc.) |
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|  |
| 4. Attitude and adjustment: (What can applicant do with remaining capacities?)  |
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|  |
|  |
|  |
| **I. SOCIAL INFORMATION (continued)**C. Mental ability: Evaluate briefly from your observation, noting any unusual behavior and, if pertinent, include applicant's ability to read, write, handle finances, participate in interview, understand and follow directions, etc. |
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D. If currently employed, state in detail the type of work, the amount and kind of physical activity involved, the supervision required, and average monthly earnings and hours worked. Is the work subsidized, required by KDHE, or sheltered?

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| E. Disability Benefits: Has the applicant ever filed for Social Security or Supplemental Security Income disability benefits?  |

 Date Filed Date Claim Allowed Date Claim Denied

OASDI: \_\_\_\_\_ No \_\_\_\_\_Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SSI: \_\_\_\_\_ No \_\_\_\_\_ Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Indicate any reason for denial of claim (or attach documentation of denial):

**II. MEDICAL HISTORY**

|  |  |  |
| --- | --- | --- |
| List the name, address and telephone number of the  DOCTOR WHO HAS CLAIMANT'S MEDICAL RECORDS. | If claimant has no doctor,check here: |  |

|  |
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|  |
| Name |
|  |
| Address (Street, City, State, Zip) |
|  |
| Reasons for Visits |
|  |
| Type of Treatment Received |
|  |
| B. Has claimant seen ANY OTHER DOCTOR since his illness or injury began?  |
|  |  | Yes |  | No | If ''Yes,'' show the following: |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Name |
|  |
| Address (Street, City, State, Zip) |
|  |
| How Often Does Claimant See Him? | Date Claimant First Saw Him? |
|  |  |
| Reasons for Visits |
|  |
| Type of Treatment Received |

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| If the claimant has seen OTHER DOCTORS since his illness began, list their names, addresses, dates and reasons for visits under ''Remarks,'' Page 7. |

**II. MEDICAL HISTORY (continued)**

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| C. Has claimant been HOSPITALIZED or treated at a CLINIC for his illness or injury?  |
|  |  | Yes |  |  | No | Yes if ''Yes,'' show the following:  |
|  |
| Name of Hospital or Clinic | Patient or Clinic Number  |
|  |  |
| Address (Street, City, State, Zip) |
|  |

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| Was claimant an inpatient? (Stayed at least overnight)  |
|  | Yes |
|  |
| Was claimant an Outpatient? |
|  | Yes |
| Reason for Hospitalization or Clinic Visits |
|  |
| Type of Treatment Received |

If claimant has been in other hospitals or clinics for his illness or injury, list the names, addresses, patient or clinic numbers, dates and reasons for hospitalization or clinic visits under ''Remarks,'' Page 7.

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| D. Has claimant been seen by OTHER AGENCIES for his injury or illness? (VA, Workmen's Compensation, Vocational Rehabilitation, Mental Health Center, State Institution, etc.) |
|  |  | Yes |  |  | No | If ''Yes, show the following:  |
|  |
| Name of Agency  | Claim Number  |
|  |  |
| Address (Street, City, Town, Zip) |
|  |
| **II. MEDICAL HISTORY (continued)**Dates of Visits |
|  |
| Type of Treatment or Examination Received |
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| **III. INFORMATION ABOUT YOUR EDUCATION** |
| A. What is the highest grade of school that you completed and when? |
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| B. Have you gone to trade or vocational school or had any type of special training?  |
|  |  | Yes |  |  | No | If ''Yes,'' show:  |
| The type of trade or vocational school or training |
|  |
| Approximate dates you attended |
|  |
| How the schooling or training was used in any work you did |
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| 1. **INFORMATION ABOUT THE WORK YOU DID**
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| List all jobs you have had in the past 15 years before you stopped working, beginning with your usual job. Normally, this will be the kind of work you did the longest. (If you have a 6th grade education or less and did only heavy unskilled labor for 35 years or more, list all of the jobs you have had since you began to work. If you need more space, list under ''Remarks,'' Page 7. |
|  JOB TITLE(Be sure to begin with your usual job.) | TYPE OF BUSINESS |  DATES WORKED (Month and Year)From To | DAYS PER WEEK |  RATE OF PAY (Per hour, day, week, month, year) |
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| **IV. INFORMATION ABOUT THE WORK YOU DID** (continued) |
| Provide the following information for your usual job shown in Item A, Line 1. |
| In your job did you: | Use machines, tools or equipment of any kind? |  | Yes |  | No |
|  | Use technical knowledge or skills? |  | Yes |  | No |
|  | Write material, complete reports, or performsimilar duties?  |  | Yes |  | No |
|  | Have supervisory responsibilities? |  | Yes |  | No |
|  |
| C. Describe your basic duties (Explain what you did and how you did it.) below. Also, explain all ''Yes'' answers by giving a FULL DESCRIPTION of the types of machines, tools, or equipment you used and the exact operation you performed, the technical knowledge or skills involved, the type of writing you did, and the nature of any reports, and the number of people you supervised and the extent of your supervision. |
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| D. Describe the kind and amount of physical activity this job involved during a typical day in terms of: |
|  |  |  | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
|  |
|  | 1. | Walking | Walking (Circle the number of hours a day spent walking.) | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
|  | 2. | Standing | (Circle the number of hours a day spent standing.) | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
|  | 3. | Sitting | (Circle the number of hours a day spent sitting.) | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
|  |  |  | (Circle how often a day you had to bend.) |
|  | 4. | Bending | Never | Occasionally | Frequently | Constantly |   |
|  |  |  |  |  |  |   |   |
|  | 5. | Reaching | Never  | Occasionally | Frequently | Constantly |  |
|  |  |  |   |  |  |  |   |
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|  |   | **IV. INFORMATION ABOUT THE WORK YOU DID** (continued) |
|   |  |   |  |  | WEIGHT FREQUENTLY LIFTED/CARRIED |
| 6. Lifting and Carrying  |  | 10 lbs.  |  |  | Up to 10 lbs. |
| Describe below what was lifted and how far it was carried: |  | 20 lbs.  |  |  | Up to 25 lbs. |
|  |  | 50 lbs.  |  |  | Up to 50 lbs. |
| Check the heaviest weight lifted and the weight frequently lifted and/or carried: |  | 100 lbs. |  |  | Over 50 lbs. |
|   |  |  |  |  | Over 100 lbs. |
|  |  |  |
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| --- | --- | --- | --- | --- |
|  | HEAVIEST WEIGHT LIFTED  |  |  | WEIGHT FREQUENTLY LIFTED/CARRIED |
|  | 10 lbs.  |  |  | Up to 10 lbs. |
|  | 20 lbs.  |  |  | Up to 25 lbs. |
|  | 50 lbs.  |  |  | Up to 50 lbs. |
|  | 100 lbs. |  |  | Over 50 lbs. |
|  |  |  |  | Over 100 lbs. |
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| **V. REMARKS** |
| See this section for additional space to answer any previous questions and to explain any other social factors which you feel should be considered in determining if disability exists. |
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