P.O. Box 3599
Topeka, KS 66601-9738
Phone: 1-800-792-4884

DISABILITY DETERMINATION REQUEST – MEDICAL ASSISTANCE CASE

I. IDENTIFYING INFORMATION: To be completed by KDHE

Claimant's First Name: ___________________ Middle: __________________ Last: _____________________________

Social Security Number: _______________ Date of Birth: ____________ Case Number: __________________

Primary Occupation:____

Approximate Monthly Income: ____________________ Currently Employed: ☐ Yes ☐ No

II. REFERRAL INFORMATION: To be completed by KDHE

Application Date: __________________________ Onset Date Requested: ________________________

SOBRA ☐ Transfer of property ☐ Working Healthy ☐ Child ☐

Deceased ☐ If deceased, date of death: _____________________

Social Security Denial: Date: ___________ Reason: ____

Verification: ____

Is this a reconsideration: ☐ No ☐ Yes If yes, enter reconsideration application date: ____________________

Signature (KDHE Worker):_______________________________________ Date: __________________________

III. DISABILITY DETERMINATION INFORMATION: To Be Completed by DDS

Allowed ☐ Denied ☐ Continued ☐ Ceased ☐ Onset Date: ____________________

Diagnosis:____

____

____

____

Basis for Determination, Treatment, Recommendations, and/or Remarks: ____

____

____

____

____

IV. REFERRAL AND/OR RECOMMENDATION INFORMATION: To Be Completed by DDS

	Yes	No	Date
Vocational Rehabilitation Referral	☐	☐	
Recommended Medical Re-examination	☐	☐	
Blind Services Recommended	☐	☐	

Signature (Disability Examiner):____ Date:______________

Signature (Medical Consultant): ____ Date: ______________