Kansas
Department of Health and Environment
Division of Health Care Finance

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

DISABILITY DETERMINATION DATA/REPORT

Medical Assistance Case

Claimant's First Name:_____ Middle: _____ Last:_____

Social Security Number: _____ Date of Birth: _____ Case Number: _____

I.SOCIAL INFORMATION

Give social information based on claimant'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.

_____
_____
_____
_____

B. **Effect of claimant's disability:** Describe in terms of:

1. Mobility and limitation of ordinary physical activities:

_____
_____
_____
_____

2. Dependence on others for help or service:

_____
_____
_____
_____

3. Appliances or prostheses necessary: (for example: hearing aid, crutches, artificial limb, etc.)

_____
_____
_____
_____

4. Attitude and adjustment: (What can claimant do with remaining capacities?)

_____
_____
_____
_____
_____

I. SOCIAL INFORMATION (continued)

C. **Mental ability**: Evaluate briefly from your observation, noting any unusual behavior and, if pertinent, include claimant's ability to read, write, handle finances, participate in interview, understand and follow directions, etc.

_____
_____
_____
_____

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?

_____
_____
_____
_____

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

Mark the following boxes as applicable:

	No	Yes	Date filed	Date Claim Allowed	Date Claim Denied
OASDI:					
SSI:					

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

II. MEDICAL HISTORY

A. Has the claimant seen a doctor/clinic/medical provider for the illness or injury? ☐No ☐Yes

If "Yes," provide the following for each provider that has the claimant's medical records.

Provider's Name:_____

Address (Street, City, State, Zip): _____

Phone:_____
Reasons for Visits:_____
_____
_____
_____
_____

Type of Treatment Received:_____
_____
_____
_____

Date this provider was first seen: _____ Date this provider was last seen: _____

Provider's Name:_____

Address (Street, City, State, Zip): _____

Phone:_____
Reasons for Visits:_____
_____
_____
_____
_____

Type of Treatment Received:_____
_____
_____
_____

Date this provider was first seen: _____ Date this provider was last seen:_____

If there were additional providers involved with this claim, please make a copy of page 3 and attach them to this form.

II. MEDICAL HISTORY - continued

B. Has claimant been HOSPITALIZED or treated at a CLINIC/ INSTITUTION for the illness or injury? ☐No ☐Yes

If "Yes," provide the following for each hospitalization:

Name of Hospital or Clinic: _____

Address (Street, City, State, Zip): _____

Phone: _____

Was claimant an inpatient? (Stayed at least overnight.) ☐No ☐Yes

What were the dates of admission and discharge for the stay: _____ to _____

At any time during this hospital stay was the condition “critical”? ☐No ☐Yes

If yes, explain:_____

Was claimant an Outpatient? ☐No ☐Yes

Reason for Hospitalization or Clinic Visits: _____

Type of Treatment Received: _____

Name of Hospital or Clinic: _____

Address (Street, City, State, Zip): _____

Phone: _____

Was claimant an inpatient? (Stayed at least overnight.) ☐No ☐Yes

What were the dates of admission and discharge for the stay: _____ to _____

At any time during this hospital stay was the condition “critical”? ☐No ☐Yes

If yes, explain:_____

Was claimant an Outpatient? ☐No ☐Yes

Reason for Hospitalization or Clinic Visits: _____

Type of Treatment Received: _____

If there were additional hospitalizations involved with this claim, please make a copy of page 4 and attach them to this form.

II. MEDICAL HISTORY - continued

C. Has claimant been seen by OTHER AGENCIES for his injury or illness? (VA, Workmen's Compensation, Vocational Rehabilitation, etc.) ☐No ☐Yes

If "Yes, provide the following for each agency:

Name of Agency: _____

Address (Street, City, Town, Zip): _____

Phone: _____

Claim Number: _____

Dates of Visits: _____

Type of Treatment or Examination Received: _____

_____

_____

Name of Agency: _____

Address (Street, City, Town, Zip): _____

Phone: _____

Claim Number: _____

Dates of Visits: _____

Type of Treatment or Examination Received: _____

_____

_____

Name of Agency: _____

Address (Street, City, Town, Zip): _____

Phone: _____

Claim Number: _____

Dates of Visits: _____

Type of Treatment or Examination Received: _____

_____

_____

If there were additional agencies involved with this claim, please make a copy of page 5 and attach them to this form.

III. INFORMATION ABOUT YOUR EDUCATION

A. What is the highest grade of school that you completed and when?_____

_____

Name and address of School:_____

_____

Were you on an IEP? ☐ No ☐ Yes Date of last IEP:_____

B. Have you gone to trade or vocational school or had any type of special training? ☐ No ☐ Yes

If "Yes," provide the following:

Name and address of School:_____

_____

The type of school or training:_____

Approximate dates you attended:_____

IV. INFORMATION ABOUT THE WORK YOU DID

A. 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 the jobs you have had since you began to work.)

JOB TITLE Begin with your usual job	Type of Business	Dates worked (month and Year) From	 To	Days per week	Rate of Pay Per hours, day, week, month, year

IV. INFORMATION ABOUT THE WORK YOU DID- continued

Provide the following information for each job listed in the chart on the previous page.

B. Job Title: _____

In your job did you: Use machines, tools or equipment of any kind? ☐No ☐Yes

Use technical knowledge or skills? ☐No ☐Yes

Write material, complete reports, or perform similar duties? ☐No ☐Yes

Have supervisory responsibilities? ☐No ☐Yes

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.

_____
_____
_____
_____
_____
_____

D. Describe the kind and amount of physical activity this job involved during a typical day in terms of:

1. 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
4. Bending (select how often you had to bend.) ☐ Never ☐Occasionally ☐Frequently ☐Constantly
5. Reaching (select how often you had to reach.) ☐ Never ☐Occasionally ☐Frequently ☐Constantly
6. Lifting and Carrying Describe below what was lifted and how far it was carried:

_____
_____
_____
_____

E. Check the heaviest weight lifted and the weight frequently lifted and/or carried:

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.

For each additional job worked in the past 15 years, please make copies of this page and attach them to the form.

V. REMARKS

Use this space to expand on any previous questions or explain any other factors which you feel should be considered in determining if a disability exists.

_____ _____

Primary Claimant must sign here Date

_____ _____

Other Adult, such as parent, spouse, **or Medical Representative** print and sign here (optional) Date

_____ _____

If Primary Claimant is unable to sign, or signed with an "X", have a first witness sign here Date

_____ _____

If Primary Claimant is unable to sign, or signed with an "X", have a second witness sign here Date

If this form was completed by someone other than the claimant:

Printed Name: _____ Phone Number: _____

Mailing Address: _____ E-mail: _____

We provide interpreter services at no cost.