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 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	☐	☐	
Working Healthy - Medically Improved	☐	☐	

Signature (Disability Examiner):_____ Date:_____

Signature (Medical Consultant): _____ Date: _____