Kansas Department of Health and Environment

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KanCare

DISABILITY DETERMINATION DATA/REPORT

Medical Assistance Case

DD-1105
11-16

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.

B. Effect of applicant'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 applicant do with remaining capacities?)

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.

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 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: ____

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

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)

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)

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.

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

III. INFORMATION ABOUT YOUR EDUCATION

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

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

IV. INFORMATION ABOUT THE WORK YOU DID

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)

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 perform similar 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.

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

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	

IV. INFORMATION ABOUT THE WORK YOU DID (continued)

6. Lifting and Carrying

Describe below what was lifted and how far it was carried:

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.

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.