ES-3903
07/10

Kansas Health Policy Authority
Presumptive Medical Disability Determination
Questionnaire

KHPA Use Only
PMDD #_____
SRS Case # _____
SSN _____

If you have questions or need help call PMDT toll-free at 1-888-547-2763. In Topeka call 296-1849.

1. Date you applied for Social Security Disability: _____

2. Complete Name (First, MI, Last): _____

3. Current Address: _____

4. Telephone Number Where You Can Be Reached: _____

5. Date of Birth: _____6. Age: _____

7. Height: _____ 8. Weight: _____

9. Do you understand English? YES ◯ NO ◯

10. What language do you prefer? _____

11. Which of the following best describes where you have lived during the past 6 months? If you have lived in more than one location, please check each location that applies.

- ◯ Own Home
- ◯ Rent Home
- ◯ Live with relative(s)
- ◯ Live with friend(s)
- ◯ Other (please describe) _____
- ◯ Live in a shelter
- ◯ Section 8 or HUD housing
- ◯ Homeless

12. Do you have public transportation (e.g., buses) in your home area?

◯ YES ◯ NO

13. Do you have a driver's license?

◯ YES ◯ NO

14. How do you travel around? Please check each one that you use.

- ◯ Own car
- ◯ Ride with a relative or friend
- ◯ Use public transportation
- ◯ Other (Please describe) _____
- ◯ Walk
- ◯ Ride bicycle
- ◯ Use special transportation (wheelchair van, etc.)

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15. Circle the highest grade of school you completed:
1 2 3 4 5 6 7 8 9 10 11 12 GED College: 1 2 3 4 or more

16. Did you attend special education classes in high school? ◯ YES ◯ NO

17. If you are under 50 years of age, list the jobs you have had in the past 5 years before you became unable to work.
If you are 50 years of age or older, list the jobs you have had in the past 15 years before you became unable to work.

32 hours or more per week is full time (FT) and less than 32 hours per week is part time (PT).

Job Title (e.g., cook)	Type of Business (e.g., restaurant)	Date Started (month/year)	Date Ended (month/year)	Full or Part Time (FT or PT)

18. Of the services listed below, what 3 do you need the most?
Place a 1 beside the one that is most important; place a 2 beside the second most important; place a 3 beside the third most important.

- ☐ A job
- ☐ Money
- ☐ Health Care
- ☐ Food Assistance/Food Stamps
- ☐ Housing
- ☐ Transportation
- ☐ Utility Assistance
- ☐ Other (Please describe) _____

19. On what date did you stop working because of your condition? _____

20. Why do you think you cannot work? Limit your answers to the top 3 reasons. Place a 1 beside the one that is the most important reason; place a 2 beside the second most important reason; place a 3 beside the one that is the third most important reason.

- ☐ Health Problems
- ☐ Cannot Find Work
- ☐ Lack of Housing
- ☐ Lack of Transportation
- ☐ Not Enough Work Experience
- ☐ Lack of Education or Training
- ☐ Lack of Necessities (clothing, personal products such as soap, shampoo, etc.)
- ☐ Other (Please describe) _____

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21. List your physical or mental conditions that limit your ability to work.

1.
2.
3.
4.
5.

22. How do your physical or mental problems limit your ability to function on a daily basis? Consider the physical or mental conditions listed in the previous question when answering.

23. Are there activities you were able to do before that you can't do now because of your illness/condition?

24. Have you been to a doctor OR WILL you go to a doctor for Social Security?

◯ YES ◯ NO ◯ I don't know

25. If you have seen a doctor for Social Security, please fill in the following:

When (Date)	Where	Mental or Physical (M or P)

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26. List your providers and doctors, current, past and future:

Doctor's Name	Specialty	Name of Clinic/Address/Phone	Date First Seen	Date Last Seen	Next Appt.

27. List the clinics, hospitals and emergency rooms you have visited:

Name	Address/Phone/Reason for Visit	Date In	Date Out

28. Have you ever had a psychiatric hospitalization? ◯ YES ◯ NO

29. IF YES, list the most recent: Name of hospital and date last admitted:

30. Have you ever received treatment for substance abuse? ◯ YES ◯ NO

31. IF YES, list the most recent: Name of facility and date last admitted:

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32. List the medications you take and why you take them. Give the doctor's name for prescriptions.

Check if taking now	Name	Why you take it	Prescribed by Dr. Name

33. List the medical tests you have had or are going to have in the future. When giving body parts, be specific, like, 'right knee.'

Name	Body Part	Date	Place Done	Doctor Name Who Ordered
Biopsy				
Breathing test				
Cardiac Catheterization				
Cardiac testing-EKG				
Cardiac testing-Treadmill				
EEG (brain wave test)				
Mental testing				
MRI/CT Scan				
Speech/language test				
Vision test				
X-Ray				
Other				