STATE OF KANSAS
DEPT OF SOCIAL & REHABILITATION SERVICES
ECONOMIC & EMPLOYMENT SUPPORT

ES-3906
08/10

Presumptive Medical Disability Determination

Notification of Changes and Final Decision Form

To: _____ Eligibility Worker Name: _____

_____ E-mail Address: _____

_____ SRS Region: _____

Phone/Fax Number: _____

I. Consumer Information

Name: _____ Case Number: _____

Identification Number: _____

II. SRS Eligibility Information (to be completed by Eligibility Worker)

_____ Application Denied: ☐ Resource Ineligible ☐ Failure to Provide Required Information

☐ Failure to Cooperate ☐ Other (specify)

_____ Fair Hearing Request: Date of Request: _____ (include a copy of the request)

Comments: _____

III. PMDT Information (to be completed by PMDT staff)

_____ Unable to Develop

☐ PMDD Questionnaire not submitted

☐ HIPAA Release not submitted

☐ Complete consultative exams Date scheduled: _____

☐ Assist in obtaining medical information Date: _____

☐ Other (specify)

_____ Medical evidence of record does not meet disability criteria

_____ Disability criteria met ☐ Tier 1 ☐ Tier 2 Onset Date: _____

Comments: _____

IV. Changes/Updates (to be completed by eligibility worker or PMDT staff)

Name: Phone:

Address:

Medical Representative/Guardian/Conservator Change:

Name: Phone :

Address:

Medical Provider Change:

Name/Specialty: Phone:

Address:

Third Party Involvement:

Name/Organization

Eligibility Worker Signature: _____ **Date:** _____

PMDT Staff Signature: _____ **Date:** _____