**PLEASE ANSWER EACH QUESTION.**

KDHE Use Only

PMDD #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

KEES Case # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Today’s Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Social Security Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

If you have questions call PMDT at 1-888-547-2763. In Topeka 296-1849. Information can be faxed to 785/296-1723.

**1**. Complete Name (First, MI, Last): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2**. Current Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- | --- |
|  |  |  | |
| City | State | | Zip Code |

**3**. Telephone Number Where You Can Be Reached: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**4.** Date of Birth: ­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **5**. Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**6.** Height: \_\_\_\_\_\_\_\_\_\_\_­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **7.** Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**8.** Do you understand English? YES NO **9.** What language do you prefer? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**10.** Date you applied for Social Security Disability: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| **When (Month/Year)** | **Doctor & Location** | Mental or  Physical  (M or P) |
|  |  |  |
|  |  |  |
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**11.** If DDS has scheduled an exam for your Social Security case please fill in the following;

**12.** Have you been in prison? YES NO

If yes, please complete the following;

|  |  |
| --- | --- |
| **Release Date** | **Name of Prison** |
|  |  |
| **Location of Prison** | **City State** |
|  |  |

**13.** Are you able to drive?

YES NO

If no, please state why not \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**14.** 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 Degree: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**15.** Did you attend special education classes in high school? YES NO

If yes, please complete the following;

|  |  |  |
| --- | --- | --- |
| **High School** | **City** | **State** |
|  |  |  |

**16.** Please list your jobs.

* 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)** | **Describe your work tasks. How long did you sit, how far did you walk, how much weight did you lift or carry, did you use a computer or other equipment?** | **Date Started**  **(month/year)** | **Date Ended**  **(month/year)** | **Full or**  **Part Time**  **(FT or PT)** |
|  |  |  |  |  |
|  |  |  |  |  |
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**17**. On what date did you stop working because of your condition? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**18.** List your disabilities or medical conditions that prevent you from working.

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**19**. What activities are you unable to do because of your physical or mental disabilities/conditions?

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**20.** List your doctors for the past year:  **If this section is not completed, it will delay your disability determination.**

* For Date First Seen and Date Last Seen, please list month and year. Add pages if needed

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

**21.** List the clinics, hospitals and emergency rooms you have visited in the past year:

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Address/Phone/Reason for Visit | Date In | Date Out |
|  |  |  |  |
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**22**. Have you ever had a psychiatric hospitalization? YES NO

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

|  |
| --- |
|  |

**24**. Have you ever received treatment for substance abuse? YES NO

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

|  |
| --- |
|  |

**26.** List your medications and why you take them. Give the doctor’s name who prescribes the medication.

|  |  |  |  |
| --- | --- | --- | --- |
| Check if taking | What is the name of the medication? | Why do you take it? | Who prescribes it? |
|  |  |  |  |
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**27.** Do you use a cane, walker, or crutches that your doctor ordered?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**28.** List medical tests you have had or are going to have. When listing body parts, be specific, like, ‘right knee.’

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Test | Body Part | Date of Test | Where tested? | Who ordered the test? |
| Biopsy |  |  |  |  |
| Breathing test |  |  |  |  |
| Cardiac Catheterization |  |  |  |  |
| Cardiac testing-EKG |  |  |  |  |
| Cardiac testing-Treadmill |  |  |  |  |
| EEG (brain wave test) |  |  |  |  |
| Mental testing |  |  |  |  |
| Vision Test |  |  |  |  |
| Speech/language test |  |  |  |  |
| MRI/CT Scan |  |  |  |  |
| X-Ray |  |  |  |  |
| Other |  |  |  |  |

**SIGNATURE OF APPLICANT**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If another person helped complete this form please provide the information below. \*For court appointed guardians/conservators, please attach papers appointing you as the legal representative. For third party representatives, such as hospital assistance or mental health centers, please provide authorization signed by the applicant if you would like to speak with PMDT about an individual’s case.

|  |  |
| --- | --- |
| Name | Phone Number |
| Agency or Relationship | Date |