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

ES-3901
10-06

Presumptive Medical Disability Team Referral

Initial Referral: ☐ No ☐ Yes Date: _____ Date of Medical or GA Application: _____

Type of Referral ☐ Current GA ☐ Medicaid Only ☐ GA & Medicaid ☐ GA RN

A. Applicant Information:

Applicant Name: Last _____ First: _____

Address: _____ City: _____

State: _____ Zip: _____ County of Residence: _____ Sex: _____

Phone Number: _____ Alternate phone number: _____

Date of Birth: _____ Social Security Number: _____

Case Number: _____ Client ID: _____

B. PMDT Telephone Consultation Scheduled: Date _____ Time: _____

Case Worker: Last Name _____ First Name: _____ SRS Region/Office _____

Case Worker Telephone Number: _____ Case Worker E-mail address: _____

C. List third party (e.g., CMHC, CDDO, etc) involvement: _____

Does the applicant have a medical representative or guardian/conservator? ☐ No ☐ Yes. If yes, name and contact information: ☐ Unknown at time referral

Last Name: _____ First Name: _____

Address: _____ City: _____

State: _____ Zip Code: _____

Phone number: _____ (Day) Phone number: _____ (Evening)

D. Does the applicant have legal or Social Security representation? ___ No ___ Yes If yes, name and contact information:

Organization: _____

Last Name: _____ First Name: _____

Phone number:

E. Describe observations by staff regarding physical or mental limitations (e.g., trouble walking, confusion, hard of hearing).

_____

_____

_____

_____

Above fields are required by the PMDT to accept the Referral. FAX to the PMDT (785) 29601723.

F. List the disabling conditions/impairments: _____

_____

_____

_____

G. Has the applicant applied for Social Security Disability? ____ No ____ Yes

If yes, date of Application: _____

Outcome: Pending _____ Denied _____ If denied, date of decision: _____

Has the applicant appealed or reapplied: _____ No _____ Yes Date of appeal/application: _____

Does the applicant have a new condition that Social Security did not previously review? ____ No _____ Yes

Or has the original condition become worse : _____ No _____ Yes

H. Applicant's Doctor(s)/Psychologist(s)/Therapist(s)

Doctor's Name: Last Name: _____ First Name: _____

Address:(street): _____ City: _____

State: _____ Zip Code _____ Phone number: _____ Date Last Seen: _____

Doctor's Name: Last Name: _____ First Name: _____

Address:(street): _____ City: _____

State: _____ Zip Code _____ Phone number: _____ Date Last Seen: _____

Doctor's Name: Last Name: _____ First Name: _____

Address:(street): _____ City: _____

State: _____ Zip Code _____ Phone number: _____ Date Last Seen: _____

Additional Comments: _____

_____ _____

Case Development Specialist: Last Name First Name