Kansas Department of Health and Environment
Presumptive Medical Disability Determination
Questionnaire

ES-3903
7-12

KDHE Use Only
PMDD #___________________________

DCF Case # ________________________

SSN ______________________________

PLEASE ANSWER EACH QUESTION.
Unanswered questions can delay your disability determination.

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

Information can be faxed to 785/296-1723.

1. Complete Name (First, MI, Last): ____

2. Current Address: ____

____
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? ______________________________

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10. Date you applied for Social Security Disability: ____

11. If you have an appointment scheduled with a doctor or have seen a doctor for Social Security or Disability Determination Services, please fill in the following

When (Month/Year)	Doctor & Location	Mental or Physical (M or P)

12. Have you been incarcerated? YES ◯ NO ◯

If yes, please complete the following;

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

13. Do you have a driver's license?
◯ YES ◯ NO

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 the jobs you have had in the past.

- ✓ 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)

17. On what date did you stop working because of your condition? ________________________________

18. List your disabilities or medical conditions. (Add pages if necessary)

1.
2.
3.
4.
5.
6.

19. What can or can't you do during the day because of your physical or mental disabilities/conditions? Please give examples.

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20. List your medical providers and doctors, current, past and future: **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

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:

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

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 the medications you take 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?

27. List the medical tests you have had or are going to have in the future. 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				

30. Please tell us if another person helped you fill out this form. Complete the information about this person 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