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

Presumptive Medical Disability Determination

Notification of Changes and Final Decision Form

ES-3906
10-06

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

Failure to:
____ Complete PMDT telephone consultation Date scheduled: _____
____ 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 change: _____ Phone Change: _____
____ Phone change: _____
____ Address change: _____
____ Medical representative/guardian/conservator change:
Name: _____
Address: _____ Phone Change: _____
Medical provider change:
____ Name/Speciality: _____
Address/Phone: _____
_____
Third Party Involvement:

Comments: _____

Eligibility Worker Signature: _____ Date: _____
PMDT Staff Signature: _____ Date: _____