Presumptive Medical Disability Determination Notification of Changes and Final Decision Form

ES-3906

08/10

То:	Eligibility	/ Worker Name:
	E-mail Address:	
	SRS Re	gion:
	Phone/F	ax Number:
I. Consumer Information		
Name:	Ca	se Number:
Identification Number:		
II. SRS Eligibility Information	(to be completed by Eligibili	ty Worker)
Application Denied:	Resource Ineligible	Failure to Provide Required Information
	Failure to Cooperate	Other (specify)
Fair Hearing Request: Da	ite of Request:	(include a copy of the request)
III. PMDT Information (to be co	ompleted by PMDT staff)	
Unable to Develop		
	Questionnaire not	
submitte		
	Release not submitted	Dete setestated
-	e consultative exams	Date scheduled:
Assist in obtaining medical information		Date:
Other (s	• • /	
	rd does not meet disability crite	
Disability criteria met	Tier 1 Tier 2	Onset Date:
Comments:		
IV. Changes/Updates (to be o	completed by eligibility work	er or PMDT staff)
	sompleted by engineering work	
Name:		Phone:
Address:		
Medical Representative/Guar	dian/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: