STATE OF KANSAS
DEPARTMENT FOR CHILDREN AND FAMILIES

DISABILITY DETERMINATION REQUEST
MEDICAL ASSISTANCE CASE

DD-1104
07-02

I. IDENTIFYING INFORMATION: To be completed by DCF

A. Name (Last, First, Middle)	B. DOB	C. SSN

D. Address (Street, City, Zip)	E. Telephone No.

F. Education	G. Sex	H. Race	I. Customary Occupation

J. Currently Employed					K. Approximate Monthly Income	L. Case No.
		No		Yes		

II. REFERRAL INFORMATION: To be completed by DCF

A. Application Date	B. Social Security Denial Date	Reason	Verification	C. Onset Date Requested

D. Reconsideration					E .DCF Worker Name	F. Phone
		No		Yes, date		

G. Office/Address	H. E-Mail

I. Signature of DCF Worker	J. Date

III. DISABILITY DETERMINATION INFORMATION: To Be Completed by DDS

A. Allowed	B. Denied	C. Continued	D. Ceased	E. Onset Date

F. Diagnosis	

G. Basis For Determination, Treatment, Recommendations, and/or Remarks

IV. REFERRAL AND/OR RECOMMENDATION INFORMATION

A. Vocational Rehabilitation Referral		Yes		No		Date	
B. Recommended Medical Re-examination		Yes		No		Date	
C. Blind Services Recommended		Yes		No		Date	

Signature (Disability Examiner)	Date	Signature (Medical Consultant)	Date

This form supersedes Form DD-1104, 02-84