State Of Kansas
Department for Children and Families

DD-1106
03-13

MEDICAL ONSET DATE VERIFICATION

Name (Last, First, Middle):

SSN: Age:

Address:

Street:

City, State, Zip:

The applicant/recipient named above has recently applied or has been approved for SSI benefits. In order to determine eligibility and claim FFP on medical expenditures for the period from (Month, Day, Year) to (Month, Day, Year) the approximate medical onset date is necessary.

Please examine your records, and enter the medical onset date in the space below:

EES worker Name:

Address:

Telephone Number:

_____ _____
EES worker's signature Date

The space below is for DDS use only.

Medical onset date (Month. Day, Year): _____

Remarks:
_____
_____
_____
_____
_____
_____

_____ _____
Disability determination examiner's signature Date

Distribution: Original, DCF; CC, Disability Determination