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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**10.** Date you applied for Social Security Disability: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- |
| **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  | Mental orPhysical(M or P) |
| **When (Month/Year)** | **Doctor & Location** |
|  |  |  |
|  |  |  |
|  |  |  |

**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 |
|  |  |  |  |
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**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:

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| --- |
|  |

**26.** List the medications you take and why you take them. Give the doctor’s name who prescribes the medication.

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| --- | --- | --- | --- |
| Check if taking  | What is the name of the medication? | Why do you take it? | Who prescribes it? |
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**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 |  |