

TO: Disability Determination Services Bureau
 535 SW 7th Street
 Des Moines IA 50309
 Telephone number: 800-532-1223

Iowa Department of Human Services

Disability Transmittal

PART I - TO BE COMPLETED BY DEPARTMENT OF HUMAN SERVICES

IM Worker Name:		E-mail Address		Worker Number		Office Phone with Extension	
County Number		Office Address					
Client Name				Social Security Number			
Street				City		State	Zip Code
Birth Date		Disability Criteria – Check One <input type="checkbox"/> Child (under age 18) <input type="checkbox"/> Adult (age 18 or above)				Date of Application	
Status <input type="checkbox"/> Initial determination. Disability has not been determined by either DHS or the Social Security Administration. <input type="checkbox"/> SSI denied; decision is final; client claims a disabling condition different from or in addition to that considered for SSI. <input type="checkbox"/> SSI denied; decision final 12 months; claims condition different from or in addition to that considered for SSI. <input type="checkbox"/> SSI denied; decision not final 12 months; condition has changed or deteriorated; new 12 month period of disability claimed, SSA refused to reopen. <input type="checkbox"/> SSI denied; decision not final 12 months; no longer meets nondisability requirements for SSI; change or deterioration in condition; new 12 month period of disability. <input type="checkbox"/> Medically Needy. Department must determine disability as there is either no decision from SS on disability or the only SS decision is denial of disability for Title II (SSDI) benefits. <input type="checkbox"/> MEPD – SGA not considered in first step of disability determination. <input type="checkbox"/> Review under childhood disability regulations before enactment of Section 211(a) of PL 104-193. <input type="checkbox"/> Medicaid recipient with review of disability due (continuing disability review – CDR). <input type="checkbox"/> Terminate disability determination. <input type="checkbox"/> Change of address. <input type="checkbox"/> Other: Explain.							

PART II - TO BE COMPLETED BY DISABILITY DETERMINATION SERVICES BUREAU

1. CLIENT DISABLED				2. CLIENT NOT DISABLED			
Disability Began		MM	DD	YY	<input type="checkbox"/> Through date of current determination <input type="checkbox"/> As explained in "Remarks"		
Disability Ceased		MM	DD	YY			
Presumptive Determination				3. Diagnosis			
Date of Decision		MM	DD	YY			
Effective Date		MM	DD	YY			
Diary Date		MM	YY	Reason			
<input type="checkbox"/> None <input type="checkbox"/> Disability Review and Adult Redetermination are <u>Not</u> Required							
4. Disability Examiner				Date		Medical Consultant	
						Date	
5. REMARKS - Regulation Basis Code							