

DISABILITY DETERMINATION REQUEST



MAP-3177 (E) 01/14/2021

Date: _____

Case Name: _____

Case Number (if known): _____

If you have a disability determination from Social Security Administration (SSA), Supplemental Security Income (SSI) or Supplemental Security Income Disability (SSDI) **do not** submit this form.

First Name: _____ Last Name: _____ MI: _____
Mailing Address: _____ DOB: _____ Age: _____
Phone Number: _____ SSN (Last four Numbers only): _____

Please check (✓) the following boxes

Employed	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Visually Impaired	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hearing Impaired (TTY)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does A/R need a Medicaid waiver?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If **yes**, waiver type: _____
Language Spoken: _____ Language Written: _____

Authorized Representative (Person assisting you with the disability determination request):

First Name: _____ Last Name: _____ MI: _____
Mailing Address: _____ Phone Number: _____

Authorized Representative may (check (✓) all that apply):

Apply Renew Medicaid Application Discuss Medicaid Application/Case Receive Mail/Correspondence

Applicant/Recipient Signature: _____ Date: _____

Authorized Representative Signature: _____ Date: _____