# DISABILITY DETERMINATION REQUEST

Human Resources Administration
Department of Social Services

MAP-3177 (E) 11/29/2024

Date: _____

Case Name: _____

Case Number (if known): _____

If you have a disability determination from Social Security Administration (SSA), Supplemental Security Income (SSI) or Social Security Disability Insurance (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 | ☐ Yes | ☐ No |
| Visually Impaired | ☐ Yes | ☐ No |
| Hearing Impaired (TTY) | ☐ Yes | ☐ No |
| Does A/R need a Medicaid waiver? | ☐ Yes | ☐ 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: _____