DEMANN POU DETÈMINASYON POU ANDIKAP

Human Resources Administration
Department of Social Services

MAP-3177 (HC) 01/14/2021

Dat la: _____

Non ki nan Dosye a: _____

Nimewo Dosye (si ou konnen li): _____

Si ou gen yon detèminasyon pou andikap ou te resevwa nan men Administrasyon Sekirite Sosyal (Social Security Administrasyon, SSA), oswa Revni Sekirite Siplemantè (Supplemental Security Income, SSI) **piga** ou soumèt fòm sa a.

Prenon: _____ Non Fanmi: _____ Inisyal Dezyèm Prenon: _____

Adrès Postal: _____ Dat nesans: _____ Laj: _____

_____

Nimewo Telefòn: _____ Nimewo Sekirite Sosyal **(Sèlman 4 dènye chif yo):** _____

Tanpri tcheke (✓) bwat sa yo

Ap travay	☐ Wi	☐ Non
Pwoblèm pou wè	☐ Wi	☐ Non
Pwoblèm pou tande (TTY)	☐ Wi	☐ Non
Èske A/R bezwen yon egzanpsyon Medicaid	☐ Wi	☐ Non

Si respons la se **wi**,
ki kalite egzanpsyon: _____

Lang li pale: _____ Lang li ekri: _____

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

Siyati Aplikan/Benefisyè a: _____ Dat la: _____

Authorized Representative Signature: _____ Date: _____