☐ ABD
☐ RETRO PERIOD
☐ LONG TERM CARE
☐ X02

Month 1 Month 2 Month 3

☐ Initial Application
☐ Reactivation
☐ Remand as a result of an Appeal
☐ Pre-release

DISABILITY OR BLINDNESS DETERMINATION TRANSMITTAL

PRINT ONLY

Date Referred _____

I. Client Name: _____
Last First MI

LDSS: _____

District: _____

Social Security #: _____

Case Manager: _____

Client ID #: _____

Telephone #: _____

Application Date _____

Currently employed:
Yes ☐ See Attached completed SGA form
No ☐

_____
Date Required Information was received from the Customer/Representative

II. MEDICAL DETERMINATION

ONSET DATE _____

☐ No Medically Determinable Impairment (**Not Disabled**)
☐ Impairment(s) Not Severe (**Not Disabled**)
☐ Impairment(s) Severe but Not Expected to Last 12 Months (**Not Disabled**)
☐ Meets Listing _____ (cite listing) (**Disabled**)
☐ Equals Listing _____ (cite listing) (**Disabled**)
☐ Impairment(s) Severe but Doesn't Meet or Equal Listing (**See Section III**)
☐ Medical Evidence Needed (Specify in comment section)

COMMENTS: _____

Signatures: MRT OPHTHALMOLOGIST _____ DATE _____
MRT PHYSICIAN _____ DATE _____
MRT PSYCHOLOGIST/PSYCHIATRIST _____ DATE _____

III. MEDICAL VOCATIONAL DETERMINATION

☐ Can Still do Past Relevant Work (**Not Disabled**)
☐ Can Adjust to do Other Work that Exists in Significant Numbers in the National Economy (**Not Disabled)**
☐ Cannot Make an Adjustment to do Other Work (**Disabled**)

COMMENTS:

Signature: DISABILITY SPECIALIST: _____ DATE: _____

INSTRUCTIONS FOR FORM DHR/FIA 707

Transmittal for State Review Team

SECTION I

ABD/*Retro Period Request/X02: Place a check (✓) to identify the type of case
*Write the retro period month(s)

Initial Application/Reactivation/Remand as a result of an Appeal: Place a check (✓) in the appropriate box to identify the type of information submitted.

Date Referred: Indicate the date the referral is forwarded to the State Review Team.

Client's Name: **Print Only**.

Social Security Number: Enter the client's Social Security Number.

Client ID: Enter Customer's Client ID.

LDSS/District: Enter the appropriate Local Department Name and District Office Number.
(**Do Not Abbreviate**)

Case Manager/Telephone: Indicate the case manager's first and last name assigned to the case and the corresponding telephone number. (**Do Not Abbreviate**)

Application Date: Date of Initial Application.
Date Required Information was received: Date **all** required information was received by the local department from the Customer/Representative

Currently Employed: Check yes or no. If yes, attach the completed Substantial Gainful Activity (SGA) form. (Refer to the Medical Assistance policy)

SECTION II

THIS SECTION IS FOR DISABILITY REVIEW TEAM USE ONLY

ONSET DATE: For the purpose of the Medical Assistance disability determination, this date represents the earliest date the individual's medical condition met the definition of disabled based on the medical evidence obtained.

SECTION III

THIS SECTION IS FOR REVIEW TEAM USE ONLY

FOR 1 copy – State Review Team (White)
1 copy – Local Department Case Record (Pink)
1 copy – LDSS Control Copy (Yellow)