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	State ID Number	Social Security Number	
Street	City	State	Zip Code
Birth Date	**Disability Criteria – Check One** ☐ Child (under age 18) ☐ Adult (age 18 or above)	Date of Application	

Status

- ☐ Initial determination. Disability has not been determined by either DHS or the Social Security Administration.
- ☐ SSI denied; decision is final; client claims a disabling condition different from or in addition to that considered for SSI.
- ☐ SSI denied; decision final 12 months; claims condition different from or in addition to that considered for SSI.
- ☐ SSI denied; decision not final 12 months; condition has changed or deteriorated; new 12 month period of disability claimed, SSA refused to reopen.
- ☐ 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.
- ☐ 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.
- ☐ MEPD – SGA not considered in **first step** of disability determination.
- ☐ Review under childhood disability regulations before enactment of Section 211(a) of PL 104-193.
- ☐ Medicaid recipient with review of disability due (continuing disability review – CDR).
- ☐ Terminate disability determination.
- ☐ Change of address.
- ☐ Other: Explain.

PART II - TO BE COMPLETED BY DISABILITY DETERMINATION SERVICES BUREAU

1. CLIENT DISABLED				2. CLIENT NOT DISABLED
Disability Began	MM	DD	YY	☐ Through date of current determination
Disability Ceased	MM	DD	YY	☐ As explained in "Remarks"
Presumptive Determination				3. Diagnosis
Date of Decision	MM	DD	YY	
Effective Date	MM	DD	YY	
Diary Date	MM	YY	Reason	
☐ None ☐ Disability Review and Adult Redetermination are Not Required				
4. Disability Examiner			Date	Medical Consultant Date

5. REMARKS - Regulation Basis Code