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FLORIDA DEPARTMENT OF CHILDREN & FAMILIES

DISABILITY DETERMINATION AND TRANSMITTAL

TO BE COMPLETED BY ESS STAFF

1. **TO: Division of Disability Determination (DDD)**

2. **RETURN TO:** District:_____ Unit:_____
Phone No.:( ) ext.
ESS: _____
Address:

3. **APPLICANT:**

Last Name, First Name, MI

Street Address

City, State, Zip Code

( )
Applicant's Phone Number

5B. Case Number:

6. **Case Status:**
☐ Initial Request
☐ Disability Review
☐ Request for Hearing

Case Type:
☐ MEDS
☐ Medically Needy

Summary
☐ Determination needed per Hearing Order

4. Applicant's Social Security Number:

5A. Applicant's Date of Birth:

7. RFA Application Date: SSI Application Date:

8. Retroactive Months (earliest month):

9. Date Request Forwarded to DDD:

TO BE COMPLETED BY DDD STAFF: DETERMINATION PURSUANT TO SOCIAL SECURITY ACT AS AMENDED

10. Applicant Disabled
☐ NO
☐ YES

Disability Began: _____/_____/_____

11a. Primary Diagnosis:

11b. Secondary Diagnosis:

12. Disability Determination Due:

Type	Date	Reason
_____	_____/_____/_____	_____

13. Vocational Background:
_____ - _____

14. Occupational Years:

15. Educational Years:

16. Reg. Basis Code:

17. Med. Listing No.:

18. Voc. Rule:

19. Disability Examiner's Signature:

20. Date Examiner Signed:
_____/_____/_____

21. Date Claim Rec'd in DDD:
_____/_____/_____

22. Physician's Signature:

23. Date Physician Signed:
_____/_____/_____

24. Date Cleared:
_____/_____/_____

25. Remarks:

Distribution of Copies: Original - To Medical Folder; Copy - DDD Copy; Copy - ESS Case Record Copy; Copy - Suspense Copy