STATE OF KANSAS
DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
REHABILITATION SERVICES

MEDICAL ONSET DATE VERIFICATION

DD-1106
9-84

NAME (LAST, FIRST, MIDDLE)	SSN	AGE
ADDRESS (STREET, CITY, STATE, ZIP)	SSI APPLICATION DATE (IF KNOWN)	
	SSI DETERMINATION DATE (IF KNOWN)	

THE APPLICANT/RECIPIENT NAMED ABOVE HAS RECENTLY APPLIED OR HAS BEEN APPROVED FOR SSI BENEFITS. IN ORDER TO DETERMINE ELIGIBILITY AND CLAIM FFP ON MEDICAL EXPENDITURES FOR THE PERIOD FROM (MONTH, DAY, YEAR) ____________ TO (MONTH, DAY, YEAR) ____________ THE APPROXIMATE MEDICAL ONSET DATE IS NECESSARY.

PLEASE EXAMINE YOUR RECORDS, AND ENTER THE MEDICAL ONSET DATE IN THE BLANK SPACE BELOW:

IM WORKER (PRINT NAME)	IM WORKER'S SIGNATURE	DATE
IM WORKER'S ADDRESS		TELEPHONE NUMBER

THE SPACE BELOW IS FOR DDS USE ONLY.

MEDICAL ONSET DATE (MONTH, DAY, YEAR) ____________

REMARKS ____________

DISABILITY DETERMINATION EXAMINER'S SIGNATURE	DATE

DISTRIBUTION: WHITE, PUBLIC ASSISTANCE; YELLOW, DISABILITY DETERMINATION