DISABILITY DETERMINATION TRANSMITTAL
Mail to: DISABILITY DETERMINATION SERVICES
PO Box 243
Raleigh, NC 27602

Attn: Medicaid Unit 09, 42, or 44

Received in DDS: _____
Aid Program/Category: _____
County: _____ No: _____
County Case No:_____
Application No: _____
Worker Dist. No: _____
Application Date:_____

Name and Address of Applicant:	**Worker:** **Phone#:**
	Date Submitted:

Social Security Number:		
Date of Birth:	**Sex:**	**Phone Number:**

☐ **MAO (DMA-5009 and 5028 attached)**
☐ **Retroactive Coverage Needed**
☐ **SA – Certain Disabled (DMA-5006 and 5009 attached)**
☐ **SA (DMA-5009 and 5028 attached)**
☐ **Review Needed: Medical Re-exam established**
☐ **Prior file attached per MA-2525, IV.B.4**

Remarks
☐ **ADDITIONAL INFORMATION. Associate with application previously submitted on**_____

PRIOR ACTION
☐ **Application** ☐ **Denial**
☐ **Review** ☐ **Termination**
☐ **Ongoing**

Original date of application: _____

Pursuant to Provisions of:
☐ **Social Security Act (Medical Assistance Only)**
☐ **North Carolina Disability/Incapacity Regulations**

It is determined that the applicant is:
☐ **Under a disability since** _____
☐ **Not under a disability**
☐ **Continuing disabled**
☐ **Not continuing disabled**
☐ **Incapacitated**
☐ **Not incapacitated**

Diagnosis:
Primary:
Code No:
Other:

DIARY/RE-EXAM
Type:
Mo/Yr:
Reason:

Reg. Basis Code	**Med List No.**	**Vocational Background**	**Occ Yrs.**	**Ed Yrs.**	**VR Referral** ☐ **Previously Referred** ☐ **Recommended** ☐ **Not Recommended**

RATIONALE:
☐ **See Attached**

Date Case Released

Disability Examiner **Date**

Medical Examiner **Date**

DMA-4037 (Rev. 08/06)