DMA-4037A

HCWD

DISABILITY DETERMINATION TRANSMITTAL

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

Attn: Medicaid Unit 09, 42, or 44

Aid Program/Category: HCWD _____
County: _____ No: _____
County Case No:_____
Application No: _____
Worker Dist. No: _____
Application Date:_____

This is a Health Care for Workers with Disability Case (HCWD). SGA does not apply.

Name and Address of Applicant:

Worker: **Phone#:**

Date Submitted:

Social Security Number:

Date of Birth:	**Sex:**	**Phone Number:** **Additional Contact Numbers (work phone, neighbor's phone, etc.:**

☐ **MAO (DMA-5009 and 5028 attached)**

☐ **Retroactive Coverage Needed**

☐ **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)**

It is determined that the applicant is:

☐ **Under a disability since** _____

☐ **Not under a disability**

☐ **Continuing disabled**

☐ **Not continuing disabled**

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**