DISABILITY DETERMINATION TRANSMITTAL

Mail to: DISABILITY DETERMINATION SERVICES
2802 Mail Service Center
Raleigh, NC 27699
Attn: Medicaid Unit 09, 42, 44, or 45

Received in DDS:_____
Aid Program/Category:_____
County No: _____
Application No:_____
Application Date: _____

Name and Address of Applicant:	**Worker:** **Worker Direct Phone# & Ext.:**
	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**

DHB-4037 (Rev. 08/20)