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MEDICAID ELIGIBILITY  
FORMS AND INSTRUCTIONS

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**DOM-325 - DISABILITY DETERMINATION AND TRANSMITTAL**

**PURPOSE & USE**

This form is used to transmit all medical information and DOM Forms 323, 323A and 324 to the Disability Determination Service (DDS). DDS uses the form to record the disability or blindness decision.

**INSTRUCTIONS**

Prepare an original and 4 copies. Submit the original and 2 copies to DDS, file one copy in the case file, and the remaining copy will serve as the tickler copy. Set a tickler for 75 days from the day of mailing the file folder to DDS. If the decision has not returned from the DDS within 75 days, the Regional Office will contact the State Office as outlined in the policy in Section D.

The top portion of the form is completed by the Regional Office giving specific information about the applicant. Specify whether retroactive months of eligibility are being requested prior to the month of application.

The worker will sign and date the form and include the Regional Office address and applicant's address.

# DISABILITY DETERMINATION AND TRANSMITTAL

TO: DISABILITY DETERMINATION SERVICE

1. DECISION REQUEST: <input type="checkbox"/> Initial <input type="checkbox"/> Cont. Dis. Inv. <input type="checkbox"/> Hearing <input type="checkbox"/> RETROACTIVE FOR PERIOD:		2. SOCIAL SECURITY NUMBER	3. MEDICAID NO.
4. GRANDFATHER STATUS <input type="checkbox"/> Yes <input type="checkbox"/> No	5. DATE OF BIRTH	6. PRIOR ACTION BY DDS <input type="checkbox"/> No <input type="checkbox"/> Yes prior medical	7. APPLICATION DATE
8. CLAIMANT ADDRESS		9. MEDICAID OFFICE ADDRESS	
10. REMARKS		11. MEDICAID SPECIALIST / SUPERVISOR	12. DATE

## DETERMINATION PURSUANT TO SOCIAL SECURITY ACT, AS AMENDED

13. CLAIMANT DISABLED <input type="checkbox"/> DISABILITY BEGAN _____ CEASED _____ <input type="checkbox"/> DISABILITY CONTINUES	14. DIAGNOSIS	15. RE-EXAM <input type="checkbox"/> NONE <input type="checkbox"/> _____ (Date)
CLAIMANT NOT DISABLED <input type="checkbox"/> SEE SSA-834 FOR EXPLANATION (OR BELOW)		

16. RETROACTIVE ELIGIBILITY DECISION: <input type="checkbox"/> Not eligible during retroactive period. See above for explanation. <input type="checkbox"/> Eligible on disability or blindness during retroactive period beginning _____ and ending _____ (Date) (Date)	
17. VOCATIONAL REHABILITATION ACTION <input type="checkbox"/> SC. IN <input type="checkbox"/> SC. OUT <input type="checkbox"/> PREV. REF.	18. DISABILITY EXAMINER - DDS    DATE _____ 19. REVIEW PHYSICIAN - DDS    DATE _____

20. REMARKS