

# 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:			<input type="checkbox"/> MAO (DMA-5009 and 5028 attached) <input type="checkbox"/> Retroactive Coverage Needed <input type="checkbox"/> Prior file attached per MA-2525, IV.B.4	
Date of Birth:	Sex:	Phone Number:		
			<input type="checkbox"/> ADDITIONAL INFORMATION. Associate with application previously submitted on _____	
REMARKS <input type="checkbox"/> ADDITIONAL INFORMATION. Associate with application previously submitted on _____				

Pursuant to Provisions of:  Social Security Act (Medical Assistance Only)

It is determined that the applicant is: <input type="checkbox"/> Under a disability since _____ <input type="checkbox"/> Not under a disability <input type="checkbox"/> Continuing disabled <input type="checkbox"/> Not continuing disabled	Diagnosis: Primary:  Code No: Other:	DIARY/RE-EXAM  Type: Mo/Yr: Reason:
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Reg. Basis Code	Med List No.	Vocational Background	Occ Yrs.	Ed Yrs.	VR Referral <input type="checkbox"/> Previously Referred <input type="checkbox"/> Recommended <input type="checkbox"/> Not Recommended
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RATIONALE:

See Attached

\_\_\_\_\_  
Date Case Released

\_\_\_\_\_  
Disability Examiner                      Date

\_\_\_\_\_  
Medical Examiner                      Date