

APPENDIX C
DES DISABILITY TRACKING FORM

Disability Determination Tracking Form

To be completed by AU Manager

1. Name (Last, First, MI)		2. Date of Birth	3. Telephone Number ()
4. Address (Number and Street)		5. Case Name	
6. Case SSN		7. City/Town	
8. State		9. ZIP Code	
10. SSN		11. AU Manager's Name	
12. CAN		13. Office No.	
14. Office Telephone Number		15. Status	
<input type="checkbox"/> TAFDC Applicant <input type="checkbox"/> TAFDC Recipient <input type="checkbox"/> EAEDC Applicant <input type="checkbox"/> EAEDC Recipient Number of months of time-limited benefits remaining for individual named in #1 _____. If a <i>TAFDC two-parent</i> assistance unit, number of months of time-limited benefits remaining for the other parent _____.		15A. Priority Has the individual received a decision of "not disabled" within the previous 60 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Individual <input type="checkbox"/> Family		16. Review/Request Date	
17. Date to PRO			

To be completed by Professional Review Organization (PRO)

18. PRO Decision Date	19. Decision		
	Disabled? Decision Code	SSI <input type="checkbox"/> Yes <input type="checkbox"/> No	EAEDC <input type="checkbox"/> Yes <input type="checkbox"/> No
		TAFDC <input type="checkbox"/> Yes <input type="checkbox"/> No	
20. Onset Date	21. Diagnosis Code(s)	22. Disability Review Date	23. Fair Hearing Date
24. Disability Examiner's Signature			ID No.
25. Vocational Examiner's Signature			ID No.
26. Physician's Signature			ID No.
27. PRO Team Leader's Signature (if applicable)			ID No.

Remarks:

Instructions for Completing the Disability Determination Tracking Form

1-10: Disabled individual information: If any of this information changes, notify PRO.

11-14: Transitional Assistance Office information

15: Status Indicator: (check one)

- TAFDC Applicant or TAFDC Recipient

- record the number of months of time-limited benefits remaining whether the individual is currently **exempt** or **nonexempt**. For example, if an individual is currently exempt and has not used any time-limited benefits enter 24 months. For two-parent families the number of months remaining must be recorded for both parents, not just the parent claiming the disability.

- EAEDC Applicant or EAEDC Recipient

- indicate either EAEDC individual or EAEDC family case.

15A: Priority:

- Indicate if the individual has received a decision of “not disabled” within the previous 60 months.

16: Review/Request Date: (Circle one)

Review

- date of AU Manager’s review for continuing eligibility

Request

- date of application for EAEDC or TAFDC

17: Date to PRO: (PRO Disability Liaison use only)

Items 18 through 27 are completed by PRO.

19: Decision: Identifies the PRO disability decision.

Decision Code

- Result of the PRO determination using EAEDC or TAFDC disability criteria (see A User’s Guide: Transitional Assistance Programs and BEACON, Chapter XIII, Section H for a description of the codes.)

20: Onset Date: Start date of the individual’s disability as determined by PRO

21: Diagnosis Code(s): (PRO use only)

22: Disability Review Date: End date of the individual’s disability as determined by PRO

23: Fair Hearing Date: (PRO use only)

Remarks: For use by DTA or PRO, when warranted.