

Disability Determination Referral to Kansas Legal Services

Child age birth to 17 years

Child/Youth – age 18 to 23 years

Child's Name: _____ DCF Case Number: _____ SSN _____

Street Address: _____ City/ State : _____ Zip: _____

Telephone: _____ DOB: _____ Gender: _____ County of Residence: _____

Placement Contact Information:

Name: _____ Telephone: _____ Mailing Address: _____

Referred by (Name/Title): _____ Agency/DCF office: _____ Telephone: _____

E-mail address: _____ Date Referred to KLS _____

Medical Statement(s) Attached: Yes No

Program Type: _____ TAF CINC: Fam. Pres. Fam. Serv. Emerg. Shelter: OTHER

Snapshot of Health Conditions:

The following information will help in determining if the child has a physical or mental problem and could receive SSI. (Please check any that apply.) Remember to consider the child's age— inability to do an activity is a problem only if he or she should be capable of it at that age.

Communicating <input type="checkbox"/>	Feeding <input type="checkbox"/>	Playing <input type="checkbox"/>	With turning <input type="checkbox"/>	Understanding Speech <input type="checkbox"/>
Walking <input type="checkbox"/>	With Head Control <input type="checkbox"/>	Washing <input type="checkbox"/>	Socializing <input type="checkbox"/>	Using the bathroom <input type="checkbox"/>
Going to School <input type="checkbox"/>	With School Performance <input type="checkbox"/>	Speaking <input type="checkbox"/>	Crawling <input type="checkbox"/>	Other <input type="checkbox"/>
Swallowing <input type="checkbox"/>	Eating <input type="checkbox"/>	Dressing <input type="checkbox"/>	Paying Attention <input type="checkbox"/>	Explain: _____
Is the child in a special education class? Yes <input type="checkbox"/> No <input type="checkbox"/>	Is the child in a special needs school? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Has an SSI application ever been made for the child? Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, when _____ Results: _____			
Are parental rights severed on this child? Yes <input type="checkbox"/> No <input type="checkbox"/>	Are there reports of child abuse or neglect on file? Yes <input type="checkbox"/> No <input type="checkbox"/>			

Medical Diagnosis, if known _____

I.E.P. in School: Yes No Is Referral for a Continuing Disability Review? Yes No

Authorization to Release Information:

Now on this _____ day of _____ 20 _____, I (Name): _____

hereby consent and authorize the Kansas Department for Children and Families to release any and all records and information in their possession, control, and custody to Kansas Legal Services for the purpose of providing advice and/or representation concerning the above named client's Social Security disability claim. I release the Kansas Department for Children and Families from any liability for giving such information.

I also consent and authorize Kansas Legal Services to release any and all records and information in their possession, control, and custody concerning advisement and/or representation of the above named client's Social Security disability claim to the Kansas Department for Children and Families for purposes of program administration, monitoring, and evaluation of the Social Security Disability Advocacy Project. I release Kansas Legal Services from any liability for giving such information.

Client (Parent/Guardian) Signature: _____ Date: _____

Distribution: DCF Social Worker; DCF regional office managing case; CWCMP Case Manager