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: **Telephone:** _____ **Mailing Address:** _____

Name:_____

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	☐	Feeding	☐	Playing	☐	With turning	☐	Understanding Speech	☐
Walking	☐	With Head Control	☐	Washing	☐	Socializing	☐	Using the bathroom	☐
Going to School	☐	With School Performance	☐	Speaking	☐	Crawling	☐	Other	☐
Swallowing	☐	Eating	☐	Dressing	☐	Paying Attention	☐	Explain: _____	

Is the child in a special education class? Yes ☐ No ☐ Is the child in a special needs school? Yes ☐ No ☐

Has an SSI application ever been made for the child? Yes ☐ No ☐ If yes, when _____ Results: _____

Are parental rights severed on this child? Yes ☐ No ☐ Are there reports of child abuse or neglect on file? Yes ☐ No ☐

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

Kansas
Department for Children and Families
Prevention and Protection Services

Strong Families Make a Strong Kansas