# FIA/DDO/17-001-S ATTACHMENT Q

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Signature: DISABILITY SPECIALIST:

DATE:

DHR/FIA 707 (revised 9/25/13)

# **INSTRUCTIONS FOR FORM DHR/FIA 707**

## **Transmittal for State Review Team**

## **SECTION I**

ABD/\*Retro Period Request/X02: Place a check ( $\checkmark$ ) to identify the type of case \*Write the retro period month(s)

Initial Application/Reactivation/Remand as a result of an Appeal: Place a check ( $\checkmark$ ) in the appropriate box to identify the type of information submitted.

Date Referred: Indicate the date the referral is forwarded to the State Review Team.

Client's Name: Print Only.

Social Security Number: Enter the client's Social Security Number.

Client ID: Enter Customer's Client ID.

LDSS/District: Enter the appropriate Local Department Name and District Office Number. (**Do Not Abbreviate**)

Case Manager/Telephone: Indicate the case manager's first and last name assigned to the case and the corresponding telephone number. (**Do Not Abbreviate**)

Application Date: Date of Initial Application. Date Required Information was received: Date **all** required information was received by the local department from the Customer/Representative

Currently Employed: Check yes or no. If yes, attach the completed Substantial Gainful Activity (SGA) form. (Refer to the Medical Assistance policy)

# SECTION II

THIS SECTION IS FOR DISABILITY REVIEW TEAM USE ONLY

**ONSET DATE:** For the purpose of the Medical Assistance disability determination, this date represents the earliest date the individual's medical condition met the definition of disabled based on the medical evidence obtained.

### SECTION III

## THIS SECTION IS FOR REVIEW TEAM USE ONLY

FOR 1 copy – State Review Team (White) 1 copy – Local Department Case Record (Pink) 1 copy – LDSS Control Copy (Yellow)