DEMANN POU DETÈMINASYON POU ANDIKAP

MAP-3177 (HC) 02/10/2023

Dat la: ______________________

Non ki nan Dosye a: ______________________

Nimewo Dosye (si ou konnen li): ______________________

Si ou resevwa avantaj Administrasyon Sekirite Sosyal pou Andikap (Social Security Administration, SSA), Revni Sekirite Siplemantè (Supplemental Security Income, SSI) oswa Asirans Sekirite Sosyal pou Andikap (Social Security Disability Insurance, SSDI), **pa** soumèt fòmilè sa a.

Prenon: ______________________ Non Fanmi: ______________ Inisyal Dezyèm Prenon: ______

Adrès Postal: ______________________ Dat nesans ______________ Laj: ______

____

Nimewo Telefòn: ______________________ Nimewo Sekirite Sosyal **(Sèlman 4 dènye chif yo):** ______________

Tanpri tcheke (✓) bwat sa yo

Ap travay	☐ Wi	☐ Non
Pwoblèm pou wè	☐ Wi	☐ Non
Pwoblèm pou tande (TTY)	☐ Wi	☐ Non
Èske A/R bezwen yon egzanpsyon Medicaid	☐ Wi	☐ Non

Si respons la se **wi**,
ki kalite egzanpsyon: ______________________

Lang li pale: ______________ Lang li ekri: ______________

Authorized Representative (Person assisting you with the disability determination request):

First Name: ______________________ Last Name: ______________________ MI: ______

Mailing Address: ______________________ Phone Number: ______________

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Authorized Representative may (check (✓) all that apply):

☐ Apply Renew Medicaid Application ☐ Discuss Medicaid Application/Case ☐ Receive Mail/Correspondence

Siyati Aplikan/Benefisyè a: ______________________ Dat la: ______________

Authorized Representative Signature: ______________________ Date: ______________