

Ohio Department of Medicaid
SOCIAL SUMMARY REPORT FOR DISABILITY DETERMINATION

Section 1 – Individual’s Identifying Information				
Case Number	Medicaid ID	Social Security Number	Date of Birth	Sex
Last Name		First Name		M.I.
Section 2 – County Agency Identifying Information				
County Agency Name		Caseworker Name	Caseload ID	Caseworker/Agency Phone
County Agency Address		City	State	Zip Code
Section 3 – Individual’s Current Disabling Medical Conditions/Observations (Most Severe to Least Severe)				
Disability:		Requested Onset Date:	How Condition Prevents Individual from Working:	
Section 4 – Individual’s Current Health Care Providers (Last 18 Months)				
Physician/Specialty:		Hospital:	Address:	
Section 5 – Individual’s Education History				
Highest Grade Completed:	Special Education (K-12): <input type="checkbox"/> Yes <input type="checkbox"/> No	Individual Can Read: <input type="checkbox"/> Yes <input type="checkbox"/> No	Individual Can Write: <input type="checkbox"/> Yes <input type="checkbox"/> No	Individual Understands English: <input type="checkbox"/> Yes <input type="checkbox"/> No
Describe Special Education:				
Specialty Degrees, Apprenticeships, Vocational Training:				
Section 6 – Individual’s Work Background				
<input type="checkbox"/> No Employment History				
Employed From:	Employed To:	Employer Name:	Reason for Leaving:	Job Duties:

Last Name	First Name	M.I.	Medicaid ID	Social Security Number
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Section 7 – Individual’s Personal Information

Living Arrangement: <input type="checkbox"/> Alone <input type="checkbox"/> Family <input type="checkbox"/> Friend	Housing Type: <input type="checkbox"/> House/Apartment <input type="checkbox"/> Boarding House <input type="checkbox"/> Institution <input type="checkbox"/> Group Home <input type="checkbox"/> Homeless	Observed Difficulties: <input type="checkbox"/> Speaking <input type="checkbox"/> Hearing <input type="checkbox"/> Seeing <input type="checkbox"/> Understanding <input type="checkbox"/> Sitting <input type="checkbox"/> Walking	Performs Own Personal Needs: <input type="checkbox"/> Yes <input type="checkbox"/> No	Participates in Social Activities Outside the Home: <input type="checkbox"/> Yes <input type="checkbox"/> No
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Comments

Name of Individual Completing Form	Title of Individual Completing Form
Signature	Date Completed