RESET FIELDS

DAP REFERRAL FORM

CASE NUMBER						LINE NO.	PROG. STATUS CODE
Co.	Record Number	Cat.	GR GP	Ctr. Dig.	Dist.		

CLIENT NAME	DATE OF BIRTH	SEX ☐ M ☐ F	* RACE/ ETHNIC GROUP	SOCIAL SECURITY
ADDRESS				TELEPHONE NUMBER

TO ☐ DAP ADVOCATE ☐ IMW ☐ SSA **FROM** ☐ DAP ADVOCATE ☐ IMW ☐ SSA

☐ IMW REFERRAL TO DAP ADVOCATE	CLIENT HAS THE FOLLOWING CHARACTERISTICS FROM THE DISABILITY PROFILE # _____	# _____	# _____	# _____
COPIES OF DOCUMENTS RELATING TO THE FOLLOWING ARE ATTACHED	☐ SOCIAL HISTORY	☐ EMPLOYMENT HIDSTORY	☐ MEDICAL RECORDS	☐ NO SUPPORTING DOCUMENTATION AVAILABLE
HAS CLIENT APPLIED FOR SSI/SSDI	☐ YES	☐ NO	☐ UNKNOWN	IF YES – DATE
IF CLIENT HAS APPLIED STATUS OF APPLICATION	☐ PENDING	☐ DENIED – DATE		☐ UNKNOWN
PREVIOUSLY RECEIVED SSI/SSDI BUT TERMINATED	☐ YES	☐ NO	☐ UNKNOWN	IF YES – DATE
IF BENEFITS DENIED OR TERMINATED, HAS CLIENT APPEALED	☐ YES	☐ NO	☐ UNKNOWN	IF YES – DATE
IF APPEALED – STATUS	☐ PENDING	☐ DENIED – DATE		☐ UNKNOWN

Signature of IMW | *Telephone Number* | *Date Form Completed*

☐ CASE RECEIVED BY DAP ADVOCATE	Signature	Date

SOCIAL SECURITY ADMINISTRATION USE ONLY

CLIENT HAS APPLIED FOR SSI/SSDI	☐ YES	☐ NO	☐ UNKNOWN	IF YES – DATE
IF YES, STATUS OF APPLICATION	☐ PENDING	☐ DENIED – DATE		SEE REASON BELOW
PREVIOUSLY RECEIVED SSI/SSDI BUT TERMINATED	☐ YES – DATE		☐ NO	SEE REASON BELOW
IF BENEFITS DENIED OR TERMINATED, HAS CLIENT APPEALED	☐ YES – DATE		☐ NO	
IF APPEALED – STATUS	☐ PENDING	☐ DENIED – DATE		

REASON:

Signature of SSA Representative | *Telephone Number* | *Date Form Completed*

☐ TO TRANSMIT OTHER INFORMATION

CLIENT AGREEMENT – I agree to cooperate with staff of the _____ County Assistance Office and the SSA District Office seeking Federal SSI/SSDI Benefits for _____ .

Client's Signature | *Date*

* 1. BLACK
2. HISPANIC
3. NORTH AMERICAN INDIAN OR ALASKAN NATIVE
4. ASIAN OR PACIFIC ISLANDER
5. WHITE (Not of Hispanic Origin)
6. OTHER

☐ **– SSA** ☐ **– Advocate** ☐ **– Client** ☐ **– Case Record**

PA 731 9/08