RESET FIELDS

MEDICAL REVIEW TEAM TRANSMITTAL

COUNTY ASSISTANCE OFFICE USE ONLY

CLIENT'S NAME:	BIRTHDATE:	SOCIAL SECURITY NUMBER:
REFERRING ADVOCATE:	REFERRING COUNTY/DISTRICT:	

REASON FOR REFFERAL:

- ☐ PURSUING SSI/SSDI - REGULAR DAP CASE
- ☐ MEDICAL CARD ONLY - CHILD
- ☐ MEDICAL CARD ONLY - ADULT
- ☐ MA FOR WORKERS WITH DISABILITIES

CASE INFORMATION:

SIGNATURE:	PHONE NUMBER:	DATE:

MEDICAL REVIEW TEAM USE ONLY

☐ **ADDITIONAL INFORMATION** ☐ **REVIEW COMPLETED** DATE:

	PHONE NUMBER:	DATE:

COUNTY ASSISTANCE OFFICE USE ONLY

REQUESTED ADDITIONAL INFORMATION ATTACHED

SIGNATURE:	DATE:

MEDICAL REVIEW TEAM USE ONLY

REVIEW COMPLETED:

☐ ADDITIONAL INFORMATION ☐ REVIEW COMPLETED

	PHONE NUMBER:	DATE:

☐ CASE REVIEW (WHITE) ☐ CAO (YELLOW) ☐ MEDICAL REVIEW (PINK) ☐ CAO SUSPENSE FILE (GOLDENROD)