MEDICAL REVIEW TEAM TRANSMITTAL

COUNTY ASSISTANCE OFFICE USE ONLY

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

REASON FOR REFFERAL:

- ☐ PURSUING SSI/SSDI - REGULAR DAP CASE
- ☐ MEDICAL CARD ONLY - CHILD
- ☐ MEDICAL CARD ONLY - ADULT
- ☐ MAWD
- ☐ RETROACTIVE REQUEST DATE _____

OTHER INFORMATION:

SIGNATURE:	PHONE NUMBER:	DATE:

MEDICAL REVIEW TEAM USE ONLY

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

SIGNATURE:	PHONE NUMBER:	DATE:

COUNTY ASSISTANCE OFFICE USE ONLY

REQUESTED ADDITIONAL INFORMATION ATTACHED

SIGNATURE:	DATE:

MEDICAL REVIEW TEAM USE ONLY

REVIEW COMPLETED:

☐ ADDITIONAL INFORMATION ☐ REVIEW COMPLETE

SIGNATURE:	PHONE NUMBER:	DATE: