

CAO ADDRESS

DAP Referral Form

CASE			
Co.	Record Number	Cat.	Dist

CLIENT NAME	DATE OF BIRTH	SEX <input type="checkbox"/> M <input type="checkbox"/> F	SOCIAL SECURITY
ADDRESS			TELEPHONE NUMBER

You have recently applied for Cash Assistance (CA) and/or Medical Assistance (MA) and indicated that you have a disability. As a condition of eligibility for CA and MA benefits, you must apply for Federal Disability (SSI/SSDI) benefits through the Social Security Administration (SSA).

This form contains a statement below that indicates your intent to cooperate with both the county assistance office (CAO) and the SSA in seeking SSI/SSDI benefits. By signing and returning this agreement to the CAO, you do not have to file an application with the SSA before the CAO authorizes your CA or MA benefits.

If you do not wish to sign this form, you must verify that you have applied for SSI/SSDI benefits in order for the CAO to approve or continue your CA or MA benefits. You may file an application for SSI/SSDI benefits by contacting SSA at 1-800-772-1213, or by applying online at www.SSA.gov.

If you have already applied for SSI/SSDI benefits, please complete the following section:

DISABILITY APPLICATION HISTORY	SUPPLEMENTAL SECURITY INCOME (SSI)	SOCIAL SECURITY DISABILITY INSURANCE (SSDI)
HAVE YOU APPLIED FOR THIS BENEFIT?	<input type="checkbox"/> NO <input type="checkbox"/> YES – DATE	<input type="checkbox"/> NO <input type="checkbox"/> YES – DATE
APPLICATION STATUS, IF APPLICABLE:	<input type="checkbox"/> REJECTED – DATE: _____ <input type="checkbox"/> APPROVED – DATE: _____ <input type="checkbox"/> PENDING – DATE/TIME OF INTERVIEW: _____ <input type="checkbox"/> UNKNOWN	<input type="checkbox"/> REJECTED – DATE: _____ <input type="checkbox"/> APPROVED – DATE: _____ <input type="checkbox"/> PENDING – DATE/TIME OF INTERVIEW: _____ <input type="checkbox"/> UNKNOWN
PREVIOUSLY RECEIVED BUT TERMINATED?	<input type="checkbox"/> NO <input type="checkbox"/> YES – DATE	<input type="checkbox"/> NO <input type="checkbox"/> YES – DATE
IF BENEFITS WERE DENIED, HAVE YOU FILED AN APPEAL?	<input type="checkbox"/> NO <input type="checkbox"/> YES – DATE	<input type="checkbox"/> NO <input type="checkbox"/> YES – DATE
APPEAL STATUS, IF APPLICABLE:	<input type="checkbox"/> PENDING <input type="checkbox"/> DENIED – DATE: _____	<input type="checkbox"/> PENDING <input type="checkbox"/> DENIED – DATE: _____

CLIENT AGREEMENT – I agree to cooperate with the county assistance office and the Social Security Administration in seeking Federal SSI/SSDI benefits. I understand that my cooperation means I will apply for SSI/SSDI benefits and file an appeal if SSA denies my initial application.

Client's Signature

Date