# DAP Referral Form

Referred to: _____ Date of Referral: _____
DAP Provider

Referring Agency/Contact Person: _____ _____
Agency Contact

Phone: _____ E-mail Address: _____

Client Name: _____ Date of Birth: _____

Address: _____

Telephone:_____ Social Security Number: _____CIN# _____

Type of Assistance: TANF ____ SNA ____ MA Only ____

Date Application Denied/Benefits Terminated: _____Denial Code_____

Type of Benefits Denied/Terminated: SSI ____ SSDI ____

English speaking client? ___yes ____no If not English speaking, primary language?_____

## Referral Disposition

(Must be returned to referring agency within 60 days)

Date: _____

☐ Referred client accepted for processing and case currently open

☐ Referred client accepted for processing and case closed after short service

☐ Referred client not accepted because no appointment available

☐ Referred client not accepted because DAP provider did not hear from referred client

Referral Processed by: (Name)_____

(Phone) _____ (e-mail address) _____

I authorize _____ (DAP Provider) to share information about the status of my SSI/SSD case, including the outcome, but not my medical records or information, with _____(agency). I do not waive any other aspect of the attorney-client privilege.

_____ _____
Client Signature Date