

NEW YORK STATE

OFFICE OF TEMPORARY AND DISABILITY ASSISTANCE

SECTION I. CLIENT IDENTIFICATION INFORMATION

CLIENT'S NAME		SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH Mo. Day Year			SOCIAL SECURITY NUMBER 		
ADDRESS <input type="checkbox"/> New					TELEPHONE NUMBER ()			
ALSO KNOWN AS:	OTHER SSN's:	DATE OF MOST RECENT TEMPORARY ASSISTANCE APPLICATION OR RECERTIFICATION:			Mo.	Day	Year	
APPLICANT FOR OR RECIPIENT OF <input type="checkbox"/> Family Assistance <input type="checkbox"/> Safety Net Assistance <input type="checkbox"/> DSS Case Number _____ <input type="checkbox"/> DSS CIN _____								

SECTION II. REFERRAL

DSS INITIATED REFERRAL FOR: <input type="checkbox"/> SSI Initial Application <input type="checkbox"/> SSI Appeal <input type="checkbox"/> Other (explain): _____ _____		SSA INITIATED REFERRAL FOR: <input type="checkbox"/> Medical Assistance <input type="checkbox"/> Temporary Assistance <input type="checkbox"/> Food Stamp Benefits <input type="checkbox"/> Social Services (explain) <input type="checkbox"/> Emergency needs (explain) <input type="checkbox"/> Other (explain) (Reason for Referral) _____ _____ _____ _____	
MEDICAL IMPAIRMENT RELATED DOCUMENTATION Describe Alleged Impairment _____ _____ _____ <input type="checkbox"/> Description and Documentation of Inability or Restriction on Working Attached <input type="checkbox"/> Medical Documentation Attached <input type="checkbox"/> Social History and Assessment Attached			
REFERRING AGENCY		NAME OF WORKER	
AGENCY ADDRESS		SIGNATURE	
		DATE Mo. Day Year	TELEPHONE NUMBER ()

SECTION III. CERTIFICATION OF SSA CONTACT

SSA ACTION <input type="checkbox"/> Initial Application Filed for <input type="checkbox"/> SSI <input type="checkbox"/> RSDI <input type="checkbox"/> Appeal Filed for <input type="checkbox"/> SSI <input type="checkbox"/> RSDI <input type="checkbox"/> No application or appeal taken, or <input type="checkbox"/> case denied because _____ <input type="checkbox"/> Other (explain): _____		Date of Client Contact Mo. Day Year
SSA OFFICE		NAME OF WORKER
SSA OFFICE ADDRESS		SIGNATURE
		DATE Mo. Day Year
		TELEPHONE NUMBER ()

SECTION IV. CERTIFICATION and RELEASE AUTHORIZATION

This is to certify that this referral is made with my knowledge and approval. I authorize release of the information contained in this referral, including documentation and medical information from my temporary assistance ***and medical assistance*** (DRAW LINE THROUGH ***and medical assistance*** IF YOU WISH TO DELETE FROM AUTHORIZATION) case records, for the purpose of determining my eligibility for benefits administered by the Social Security Administration, including SSI State Supplement. I wish to protect my rights to any such benefits for which I may be eligible. I understand that my refusal to sign this release will make me ineligible for Temporary Assistance. However, I understand that my authorization for release of medical information from my Medical Assistance case record is completely voluntary and refusal will not affect my eligibility for Medical Assistance.

SIGNATURE OF APPLICANT	DATE Mo. Day Year
If another person is acting on applicant's behalf, show relationship:	