

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? Spanish

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 _____