

## PMDT REFERRAL

<b>APPLICANT INFORMATION</b>							
Last Name		First Name		M.I.			
Street Address				Apt/Unit #			
City			State		ZIP		
Phone #			DOB		SSN		
<b>REFERRAL INFORMATION</b>							
Medical Application Date			Medicaid Only	<input type="checkbox"/>	GA & Medicaid	<input type="checkbox"/>	GARN <input type="checkbox"/>
Case #			Client ID				
<b>LIST THE APPLICANT'S DISABLING CONDITIONS/IMPAIRMENTS</b>							
<i>Staff observations are very important to PMDT. Please include observations of physical or mental conditions/limitations. (E.G. Trouble walking, confusion, hard of hearing)</i>							
<b>SOCIAL SECURITY DISABILITY INFORMATION</b>							
<i>Please note it is an eligibility requirement to apply for SSA disability.</i>							
<b>Date of SSA Disability Application :</b> _____			Does the applicant have a new condition that Social Security did not previously review? _____				
Outcome: Pending? _____ Appeal? _____ Denied? _____ Reapplied? _____			Has the original condition worsened? _____				
<b>LEGAL REPRESENTATIVE (MEDICAL REPRESENTATIVE, GUARDIAN, CONSERVATOR)</b>							
<i>Please send copy of appointment of medical or legal representative with this form.</i>							
Last Name			First Name				
Address			City/State				
Zip Code			Phone #				
<b>THIRD PARTY INVOLVEMENT (HOSPITAL ASSISTANCE, MENTAL HEALTH CENTER, SOAR, KDOC)</b>							
<i>Please send signed authorization which allows PMDT to release information to the individual or organization below.</i>							
Last Name			First Name				
Address			City/State				
Zip Code			Phone #				
Organization							
<b>SUBMITTING DCF OFFICE</b>				<b>DATE</b>			