# PMDT REFERRAL

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| **APPLICANT INFORMATION** |
| Last Name |  | First Name |  | M.I. |
| Street Address |  | Apt/Unit # |  |
| City |  | State |  | ZIP |  |
| Phone # |  | DOB |  | SSN |  |
| Referral Information |
| Medical Application Date |  | Medicaid Only | [ ]  | GA & Medicaid | [ ]  | GARN | [ ]  |
| Case # |  | Client ID |  |
| List the APPLICANT’S disabling conditions/impairmentS Staff observations are very important to PMDT. Please include observations of physical or mental conditions/limitations. (E.G. Trouble walking, confusion, hard of hearing) |
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| **SOCIAL SECURITY DISABILITY INFORMATION***Please note it is an eligibility requirement to apply for SSA disability.*  |
| Date of SSA Disability Application  |  |
| **LEGAL REPRESENTATIVE (MEDICAL REPRESENTATIVE, GUARDIAN, CONSERVATOR)***Please send copy of appointment of medical or legal representative with this form.* |
| Last Name |  | First Name |  |
| Address |  | City/State |  |
| Zip Code |  | Phone # |  |
| **THIRD PARTY INVOLVEMENT (HOSPITAL ASSISTANCE, MENTAL HEALTH CENTER, SOAR, KDOC)** *Please send signed authorization which allows PMDT to release information to the individual or organization below.* |
| Last Name |  | First Name |  |
| Address |  | City/State |  |
| Zip Code  |  | Phone # |  |
| Organization |  |
| **SUBMITTING DCF OFFICE** |  | **DATE** |  |