# 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** | | |  | | | | | |