DMA-5049 01/01/95

REFERRAL TO LOCAL SOCIAL SECURITY OFFICE

TO: _____
Social Security Administration

RE: _____
(Name of Client)

_____
(Social Security Number)

_____
(Phone Number)

FROM: _____
County Department of Social Services

_____
(Medicaid ID Number)

We have secured the following information concerning the above named individual. This is for informational purposes only. Please evaluate possible effect to SSI.

1. ☐ We have screened this individual for Medicaid. He/She is being referred to you as a possible claimant for SSI benefits. (If this item is checked, do not send to SSA. Give original to individual and keep a copy.)

2. ☐ Beneficiary has entered a Title XIX institution as a patient.

   Name of Nursing Home: _____
   Address: _____
   Phone Number: _____
   Date of Entry: _____ Estimated length of stay: _____

3. ☐ Beneficiary left a Title XIX institution patient status. His/Her new address is:

   _____
   Phone Number: _____
   Date of Departure: _____

4. ☐ Beneficiary entered a public institution.
   Name of Institution: _____
   Address of Institution: _____
   Date of Entry: _____

5. ☐ Beneficiary deceased. Date of Death: _____

6. ☐ Change in income or resources of beneficiary/spouse. Specify _____
   _____

7. ☐ Beneficiary has provided third party insurance information. Please update SSI record to reflect this. The SSI record must be changed before the individual can receive Medicaid.

8. ☐ Other, specify _____

REMARKS:

_____	_____	_____
DATE	PHONE NUMBER	INCOME MAINTENANCE CASEWORKER

Attachment 1