INFORMATION AND REFERRAL FORM DSS/SSA

I. APPLICANT/RECIPIENT INFORMATION

Name _____

Last *First* *Middle*

Mailing Address:

Contact if other than applicant (phone number)	

√	*CHECK THE BOX BELOW IF THE CLIENT IS NOT MOBILE*
	This person is unable to visit your office and requires a telephone or personal contact.

II. COUNTY REFERRAL INFORMATION TO SSA

Category of Assistance				Applied for/ receiving benefits of	$
	Currently receiving Medicaid				
SSA Benefit applying for: (*check if applicable*)					
	Retirement		Survivors		Disability/SSI
	Medicare		Date of Onset:		

Adult Income Technician (print name) *Date* *Phone number*

III. SSA Referral/Information to County

	SSA Category				
	Date applied				
	Pending		Denied	Reason	
	Eligible for Payment	$		Continuing payment	$

PAYMENT HISTORY

	Amount	Date Payment made	For month:

Signature of SSA Representative *Date* *Phone number*

IV. I authorize the Social Security Administration, and the Colorado Department of Human Services, and their agents to disclose the above information for the sole purpose of assisting me in processing my application for public assistance and/or services or in determining the accuracy of any benefit to which I am, or may be entitled.

Signature of Applicant	*Date*

DO-88 (Revised 11/2007)