|  |  |  |
| --- | --- | --- |
|  | **Social Service Referral** |  |
| Date |
| **1. Client Information** |
| Case Name | Telephone Number | Client ID | Application Date |
| LEP / Primary Language |
| Address City State Zip Code |
| **2. Referral** |
| [ ]  ABD Disability / HEN Incapacity Determination[ ]  Pregnant Women Assistance (PWA) Case Management[ ]  Ongoing Additional Requirements [ ]  TANF Disability Assessment (TDA)[ ]  Refugee Cash Assistance (RCA) [ ]  TANF Time Limit Extension (TLE)[ ]  Aged [ ]  Teen Living Assessment (TLA)[ ]  Protective Payee [ ]  Other:  |
| **3. Special Criteria** |
| [ ]  SSI / SSDI Approved [ ]  Terminally ill [ ]  Active HEN Referral [ ]  Equal Access (EA) [ ]  Active ABD [ ]  Current DCS Support Order[ ]  Approved for HCS Long Term Care Services [ ]  NGMA[ ]  Approved for DDA Services [ ]  Urgent[ ]  Transitional Outreach Assistance Program (TOAP) |
| **4. Comments** |
| [ ]  Financially Eligible |