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|  | **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 | | | | |