MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF FAMILY SERVICES

SOCIAL SECURITY REFERRAL

☐ REPLY REQUESTED

COUNTY OFFICE	CASEWORKER NAME	TELEPHONE

SOCIAL SECURITY OFFICE/REPRESENTATIVE

ADDRESS (STREET, CITY, STATE, ZIP CODE)	TELEPHONE	DATE FROM TO

CLAIMANT INFORMATION

CLAIMANT NAME			SOCIAL SECURITY NUMBER
ADDRESS			PHONE
SSA CLAIM NO.	BIRTHDATE	CASE NAME (IF DIFFERENT)	CASE NUMBER

I. REFERRAL

TYPE OF ASSISTANCE	AMOUNT OF GRANT	DATE APPROVED	IS MEDICAL INFORMATION AVAILABLE? ☐ YES ☐ NO IS PART II NEEDED TO DETERMINE ELIGIBILITY? ☐ YES ☐ NO
	$		

REASON FOR REFERRAL

SSA REPORT

II. REQUEST FOR INFORMATION

REASON FOR REQUEST

Please Complete Applicable Sections

A. NAME OF CLAIMANT	B. TYPE OF BENEFIT

C. ☐ TITLE II

TLE II APPL. IN PROCESS: DATE FILED	TITLE II EXPECTED DATE OF COMPLETION
TITLE II APPL. DISALLOWED: DATE	REASON
APPLICATION APPROVED	

MONTHLY ELIGIBILITY AMOUNT
(Irrespective of adjust. for underpayments or overpayments)

DATE FROM	DATE TO	AMOUNT	DATE FROM	DATE TO	AMOUNT

CURRENT AMOUNT OF TITLE II AWARD TO
☐ SPOUSE ▶ $

D. ☐ TITLE XVI

TITLE XVI APPL. IN PROCESS DATE FILED	TITLE XVI EXPECTED DATE OF COMPLETION
TITLE XVI APPL. DISALLOWED: DATE	REASON (SDX CODE)
APPLICATION APPROVED	

MONTHLY ELIGIBILITY AMOUNT
(Irrespective of adjust. for underpayments or overpayments)

DATE FROM	DATE TO	AMOUNT	DATE FROM	DATE TO	AMOUNT

CURRENT AMOUNT OF TITLE XVI AWARD TO
☐ SPOUSE ▶ $ ☐ ESSENTIAL PERSON ▶ $

E. ARE ANY CHANGES IN AWARD AMOUNT PENDING?
☐ YES ☐ NO IF YES ▶

DATE	NEW AMOUNT
	$

F. COMMENTS

BY	SIGNATURE	SSA TITLE	DATE

THE ABOVE INFORMATION WILL BE USED FOR AND LIMITED TO THE FOLLOWING PROGRAM(S):
(YOU MAY CHECK MORE THAN ONE BOX)

- ☐ * TITLE IV - AFDC
- ☐ * TITLE XVI - SSI FOR AGED, BLIND, AND DISABLED (INCLUDES STATE SP PAYMENTS)
- ☐ * TITLE XVIII - HEALTH INSURANCE FOR THE AGED AND DISABLED (STATE BUY-IN FOR MEDICARE)
- ☐ * TITLE XIX - MEDICAL ASSISTANCE PROGRAM
- ☐ * FOOD STAMPS
- ☐ GENERAL RELIEF
- ☐ OTHER ▶ _____

* CONSENT OF CLAIMANT NOT REQUIRED

III.

I agree to this referral and/or request by the Division of Family Services to the Social Security Administration and to whatever exchange and/or release of information which may be necessary and/or helpful to complete this request. I hereby release any person and/or agency from any liability for information furnished pursuant to this agreement. I understand that this consent is valid for 90 days from this date, or, if later until SSA has completed any necessary action on the record and disclosed the requested information.

SIGNATURE OF INDIVIDUAL	DATE	SIGNATURE OF SPOUSE

IV. NEW INFORMATION

A. THE ABOVE-NAMED SSI RECIPIENT HAS APPLIED FOR SNF/ICF/MHC/IMR ON ▶

1. PREVIOUS HOME ADDRESS

CURRENT FACILITY ADDRESS

2. MOVED FROM	TO

3. DIED: DATE OF DEATH

B. THE ABOVE NAMED SSI RECIPIENT

1. BECAME INELIGIBLE FOR SNF/ICF/MHC/IMR EFFECTIVE ▶

a. BUT REMAINS IN (NAME OF FACILITY)

OR

b. LEFT (NAME OF FACILITY)	ON

2. REPORTED NEW ADDRESS

IM-5/IMU5 TRANSACTION COMPLETED

C. ACCORDING TO OUR INFORMATION, THE ABOVE NAMED SSI RECIPIENT

V. CASEWORKER	DATE COMPLETED	LOAD NUMBER