MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF FAMILY SERVICES
SOCIAL SECURITY REFERRAL

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

☐ TITLE II
☐ TITLE XVI

☐ TITLE XII APPL. IN PROCESS DATE FILED TITLE XII EXPECTED DATE OF COMPLETION
☐ TITLE XVI APPL. IN PROCESS DATE FILED TITLE XVI EXPECTED DATE OF COMPLETION

TITLE XII APPL. DISALLOWED DATE REASON
TITLE XVI APPL. DISALLOWED DATE REASON (SIX CODE)

APPLICATION APPROVED APPLICATION APPROVED

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

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

CURRENT AMOUNT OF TITLE XII AWARD TO
☐ SPouse $ 
CURRENT AMOUNT OF TITLE XVI AWARD TO
☐ SPouse $ ☐ ESSENTIAL PERSON $ 

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

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 - APICC ☐ FOOD STAMPS
☐ TITLE XVI - SSI FOR AGED, BLIND, AND DISABLED (INCLUDES STATE SP PAYMENTS) ☐ GENERAL RELIEF
☐ TITLE XVIII - HEALTH INSURANCE FOR THE AGED AND DISABLED (STATE BUY-IN FOR MEDICARE) ☐ OTHER
☐ TITLE XIX - MEDICAL ASSISTANCE PROGRAM ☐ CONSENT OF CLAIMANT NOT REQUIRED

MO 596-0167 (5-98) RETAIN CURRENT
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.

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<tr>
<th>SIGNATURE OF INDIVIDUAL</th>
<th>DATE</th>
<th>SIGNATURE OF SPOUSE</th>
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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/IMUS TRANSACTION COMPLETED

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

________________________________________

________________________________________

________________________________________

V. CASEWORKER

DATE COMPLETED | LOAD NUMBER

__________________________ | ____________________________