Presumptive Medical Disability Team Referral

Initial Referral:	No	Yes	**Date of MS or GA Application:**				
Type of Referral:	Current GA		Medicaid Only		GA & Medicaid		GA RN
PMDD Questionnaire – HIPAA Release Due Date:							
PMDD Questionnaire Attached:	No	Yes	**HIPAA Release Attached:**	No	Yes		

A. Applicant Information:

Last Name:			First Name:		
Address:			City:		
State:	Zip:		County:		Sex:
Phone #:		Alt Phone #:			DOB:
SSN:		Case #:		Client ID:	

B. List Third Party Involvement (CMHC, CDDO etc):

Does the applicant have a medical representative or guardian/conservator?	No	Unknown	Yes (name & contact info listed below)		
Last Name:			First Name:		
Address:			City:		State:
Zip Code:	Phone #:		Alt. Phone #:		
Does the applicant have legal or Social Security representation?	No	Yes (name & contact info listed below)			
Last Name:			First Name:		
Organization:			Phone #:		

C. Describe observations by staff regarding physical or mental limitations (e.g. trouble walking, confusion, hard of hearing).

D. List the disabling conditions/impairments:

E. Has the applicant applied for Social Security Disability? No Yes

If yes, date of application:	**Outcome:**	Denied	Pending
Has the applicant appealed or reapplied?		No	Yes
Does the applicant have a new condition that Social Security did not previously review?		No	Yes
Or has the original condition become worse?		No	Yes

Eligibility Worker: **Date:**