Klamath & Lake Community Action Services
Homeless Benefits Program
1803 Main St.
Klamath Falls, OR 97601
www.KLCAS.org

SSI/SSD Referral Form

Date: ____________

Please Note: KLHBP's services are available for the most severely disabled people who would not be able to navigate Social Security Administration's disability process without help. *A DECISION BY KLHBP TO NOT REPRESENT YOUR CLIENT* ***DOES NOT MEAN*** *THEY SHOULD NOT APPLY FOR BENEFITS THROUGH SOCIAL SECURITY.* It simply means they do not meet our criteria for representation.

If your client believes they are disabled and KLHBP opts not to represent them, it is very important to let them know they can, and should, contact the Social Security Administration to start the claims process on their own. Social Security Administration's telephone number is **1-800-772-1213**

Please answer all questions

Referring Agency Information

Name of referring Agency: ____

Caseworker: ________________________________ **Contact phone:** ______________

Completed Release of Information form attached? ☐ yes ☐ no

Client Information

First Name: ____________________________ **Last Name**: ________________________________

Address:____

❖ If homeless, where they can usually be found? (Gospel Mission, Veteran's Park, etc.)

Date of Birth: ________ **SSN**: ___________________ **Client's phone**: _______________

Gender: ☐ Female ☐ Male

Veteran? ☐ Yes ☐ No

Education: What grade completed?_____________________

Race: ☐ Hispanic ☐ Non-Hispanic

How does the client identify his or her ethnicity? ☐ (white, black, etc)______________________

Does client have any insurance: ☐ None, ☐ OHP/Medicaid, ☐ Medicare

☐ Private (name of insurer):____

Is this the first time the client has applied for SSI or SSDI? ☐ Yes ☐ No

If no, is there a currently open case? ☐ Yes ☐ No

Appeal needed? ☐ Yes ☐ No (60 days from last denial date)

Date of last denial: _________________ **Hearing date if any** ______________________________

Is there an attorney involved? ☐ Yes ☐ No

If yes, Atty. Name and address: ____

Which type of housing best describes your client's current living arrangement.

☐ Shelter ☐ Transitional housing ☐ Couch surfing ☐ Perm. Housing ☐ Outdoors

Is client chronically homeless? HUD Definition: last 12 mths. or 4 times in last 3 yrs. ☐ Yes ☐ No

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Briefly describe how the client became homeless and for how long?

____

Does client have any income? ☐ Yes ☐ No

If yes, check type: ☐ F/T ☐ P/T, ☐ VA, ☐ TANF, ☐ Worker's Comp., ☐Unemployment, ☐ Other

Approximately how much per month?_$________________

Do they have any property or possessions that could be turned into cash? If yes, what items?

____

Employment history

How long since last employed full-time? ____

Medical History

Disabling conditions: ____

Established diagnoses: ____

Approx. how long have the client's severe conditions been disabling? ____________________

Prior hospitalization(s):

Psychiatric (approximate dates): ____

Medical (approximate dates): ____

Primary care clinic: ____

How long with this provider? ____

Primary medications: ____

Substance abuse* ☐ Yes ☐ No (Drugs of choice) ____

Level of use: ☐ Mild ☐ Moderate ☐ Heavy

**Substance abuse/addiction alone will not qualify an individual for SSI/SSDI.*

Clean and Sober? ☐ Yes ☐ No How Long? _________

Is/was client involved in a treatment program? ☐ Yes ☐ No How Long?____________________

When & Where? ____

Briefly describe why you think this client is unable to work. Please be specific.

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PLEASE ATTACH YOUR AGENCY'S COVER SHEET AND RELEASE OF INFORMATION AND FAX COMPLETED FORM TO (541) 882-3674, ATTENTION WALT DAVIS

For questions or consultation with the KLHBP benefits specialist, please call (541) 882-3500.