



A.S.S.I.S.T. Referral Form

Date: _____

Please answer all of these questions. If you do not know the answer please ask your client.

Name of Referring Agent/Agency: _____		
Contact E-mail: _____	Contact phone: _____	
ROI Provided? <input type="checkbox"/> Yes <input type="checkbox"/> No	Claim in progress? <input type="checkbox"/> Yes <input type="checkbox"/> No	Initial app. <input type="checkbox"/>
Appeal needed? <input type="checkbox"/> Yes <input type="checkbox"/> No (60 days from last denial date)		Reconsideration <input type="checkbox"/>
Date of last denial: _____		Hearing <input type="checkbox"/>
Is there an attorney involved? <input type="checkbox"/> Yes <input type="checkbox"/> No	Atty. Name: _____	

First Name: _____ **Last Name:** _____

Address: _____ **Zip** _____

If homeless, please indicate "homeless" but **provide a zip code** of where they stay.

Shelter Subsidized housing Transitional housing Couch surfing Perm. Housing

Date of Birth: _____ (mm/dd/yyyy) **SSN:** _____

Gender: Female Male Transgender **Client's phone:** _____

Mother's maiden name: _____ **Father's name:** _____

Client's place of birth (City & State): _____

Veteran? Yes No **Race:** White, Black, Native American, Asian, Hispanic, Oceania, Middle-eastern, Indian

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

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

Is the Client Head of Household Yes No

Education: What grade completed? _____

Does client have any income? P/T work, VA benefits, TANF, Workers' Comp., Unemployment, Other

Approximately how much per month? _____

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

Brief employment history: _____

How long since last employed full-time? _____

Disabling symptoms: _____

Established diagnoses: _____

Roughly how long have the client's severe conditions been disabling? _____

Treatment history:

Psychiatric Hospitalizations? (appx dates): _____

On-going psychiatric treatment? Where? _____

Medical Hospitalizations? (appx dates) _____

On-going medical treatment? Where? _____

Primary care provider's names? _____

How long with this provider? _____

Other treatment providers? _____

Primary medications: _____

Substance abuse* Yes No (Drug of choice) _____

Level of use: Mild Moderate Heavy

Clean and Sober? Yes No How Long? _____

Is/was client involved in a treatment program? Yes No, Completed? _____

Any criminal history* _____

**This alone will not disqualify our help.*

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

PLEASE FAX COMPLETED FORM TO (503) 477-4177

Please Note: Filing a Social Security disability claim is an American right. If your client believes they are disabled and A.S.S.I.S.T. opts not to represent this person, it is very important to let them know they 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**

For free case consultations please call Mellani Calvin at 503-888-2690.

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