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

Date: _____

Please answer <u>all</u> 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? ☐ Yes ☐ No **Claim in progress?** ☐ Yes ☐ No **Initial app.** ☐
Appeal needed? ☐ Yes ☐ No (60 days from last denial date) **Reconsideration** ☐
Date of last denial: _____ **Hearing** ☐
Is there an attorney involved? ☐ Yes ☐ 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: ☐ Multiracial, ☐ Latino, ☐ Black, ☐ Indigenous American, ☐ Asian, ☐ Pacific Islander, ☐ Middle Eastern, ☐ Caucasian, ☐ Other: _____

Does client have any insurance: None, OHP/Medicaid, Medicare, Ins. Co. Name_____

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? _____

4412 S. Barbur Blvd., Suite 240 Portland, OR 97239 T: 503-888-2690 F: 503-477-4177
Email: Mcalvin@AssistDBTC.com Website: www.ProgramAssist.org

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 <u>why</u> 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 contact ASSIST at 503-888-2690.

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