AUTHORITY: Title 45 CFR - Social Security Act.
COMPLETION: Required.
PENALTY: Non-issuance of public assistance.

DHS/SSA REFERRAL
Michigan
Department of Human Services

Department of Human Services (DHS) will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.

1. **TO:**	3. **FROM:**		
2. Address	4. Address:		5. Phone Number
	6. Date	7. Load Number	8. Worker Signature

8. Name of Person				9. Date of Birth
10. Address (Number & street)	City	State	Zip Code	11. Phone Number
12. DHS Case Number	13. Social Security Account Number		14. Social Security Claim Number	
15. Name of Spouse				16. Date of Birth
17. Current Status with Referring Department				

18. CHECK AND COMPLETE APPROPRIATE SECTION(S) BELOW

☐ **Part A. ACTION REQUESTED: DETERMINATION OF LEVEL OF CARE**

Name of Facility	Date of Placement
Address	Phone Number

Children Only: ☐ State Ward ☐ Court Ward ☐ Other Supervising (Placement) Agency

AUTHORIZATION OF LEVEL OF CARE

Level of care has been determined, client qualified for: ☐ Domiciliary Care ☐ Personal Care ☐ Home for Aged Care

Authorizing Worker Signature	Phone Number	Date

☐ **Part B. OTHER ACTION REQUESTED (Describe)**

ACTION TAKEN BY RECEIVING DEPARTMENT

Receiving Department Worker Signature	Phone Number	Date

☐ **Part C. INFORMATION FOR USE BY RECEIVING DEPARTMENT**

Effective Date: Source:

19. ADDITIONAL REMARKS:

DHS/SSA REFERRAL
INSTRUCTIONS FOR USE

General: This form is used only to exchange information regarding SSI applicants and recipients. To obtain information about regular Social Security and Medicare see PAM item 800.

The purpose of this form is to exchange information with the Social Security offices. The Department of Community Health, Community Health Services, or their agents also use this form for "determination of level of care" purposes.

The Department initiating the form is called the "originating department." The department to whom the form is sent is called the "receiving department."

Items 1 through 17 are to be completed by the originating department.

- 1 - 2. Enter name and address of department to whom the form is being sent.
- 3 - 5. Enter the name, address, and telephone number of department sending the form.
- 6 - 7. Enter the date and signature of person sending the form.
- 8 - 12. These items identify the person about whom information is being requested or reported.
- 13. Enter the person's Social Security Account Number.
- 14. Enter the number under which the person is receiving RSDI or Medicare.
- 15 - 16. Enter name and birth date of spouse.
- 17. Enter current program status with originating department of person about whom information is being requested or reported. Enter program information on this line and give eligibility, closure, or denial date.
- 18. Originating department checks the appropriate block or blocks (Part A - Part B - Part C).
- 19. To be used by either department to add additional information.

PART A. ACTION REQUESTED: DETERMINATION OF LEVEL OF CARE

Requests for a level of care determination: SSA (or other department) fills in the name, address, and telephone number of the facility and the date of placement. If the SSI recipient is a child, check legal status and fill in name of supervising (placement) agency. (If any of these items are not known, the receiving department should fill in the missing information.)

Authorization of Level of Care

The Department of Human Services, Department of Community Health, Community Health Services, or their agents complete this section. The worker authorizes the proper level of care by checking one of the boxes, then signs and dates name.

A new level of care determination is required whenever a recipient moves to a different facility.

When the Department of Community Health, Community Health Services, or their agents authorize the level of care, note special instructions for distribution below.

PART B. OTHER ACTION REQUESTED

In this section the originating department can request specific information (other than level of care) or request that any department take specific action. Example: SSA may refer a person to DHS for possible assistance or request that DHS find a representative payee for a SSI recipient.

Action Taken by Receiving Department

This section is to be completed by the receiving department. Give the requested information or describe what action has been taken. The receiving department signs and dates name.

PART C. INFORMATION FOR USE BY RECEIVING DEPARTMENT

This section is to be used by the originating department to inform the receiving department of information which has come to their attention. No reply from the receiving department is expected.

The effective date is the date on which the event or relayed information took place (e.g. date of death).

The source is the person or place from whom the originating department got this information (e.g. relative, other department, etc.).

DISTRIBUTION: The originating department sends the original copy to the receiving department and retains a photo copy for the file. If a reply is needed, the receiving department returns the original copy to the originating department and retains a photo copy for the file.

NOTE: The Department of Community Health, Community Health Services, or their agents must send a photo copy to the local Department of Human Services if the person is an adult. For children, a photo copy is sent to Child and Family Services, Children's Foster Care Program, Department of Human Services, P.O. Box 30037, Lansing, MI 48909.