Government of the District of Columbia
Department of Health Care Finance

Child & Adolescent Supplemental Security Income Program Referral

REFFERING PROVIDER

Last Name:	First Name:	Street Address:	City:	ST:	ZIP:

Provider Signature:	Telephone:	Date:

BENEFICIARY

Last Name:	First:	Medicaid ID:	Birth date:	Gender: ❑ M ❑ F

Parent Last Name:	First:	Street Address:	City:	ST:	ZIP:
Parent Last Name	First:	Street Address:	City:	ST:	ZIP:

SSI Filing Date: Approved? ❑ Yes ❑ No ❑ Pending	Parent Signature:	Phone:
MCO Assignment: ❑ AHC ❑ MFC ❑ THP ❑ HSCSN	Parent Signature:	Phone:

BENEFICIARY DIAGNOSIS

Supporting documentation required

REFERRAL REASON

Attach additional documentation as needed

DHCF AUTHORIZATIONS

Date Reviewed:	Clinical Reviewer Signature:	Approved? ❑ Yes ❑ No
Enroll Effective Date:		

Comments:

❑ Refer to Case Management at Assigned MCO
❑ Additional documentation required for determination of CASSIP enrollment

Fax completed form to 202 442 4790 Attn: Office of the State Medicaid Director/CASSIP.