18. Current Month SSI Check Amount: $_____

19. Name & Telephone Number of Local TDHS Medicaid Caseworker:
    Name: _____
    Area Code & Phone #: _____

20. Name of SSA DO Employee Certifying SSI Payment for the Month Emergency Certification Being Processed: _____

21. Signature of Servicing Office OS/MSS (or above) Authorizing Use of Emergency Medicaid Certification: _____

22. SSA Servicing Office Address & Telephone Number:
    Address: _____
    _____, Texas_____
    Phone #: _____
    FAX #: _____

COMPLETION INSTRUCTIONS

- Use this form only for emergency Medicaid procedures.
- Do not use this form for routine manual Medicaid certification. Continue to use the SS-RVI-300 (02/06) in Exhibit 1.
- Provide details of the life-threatening medical emergency in Item 1. Include an explanation as to why routine procedures cannot be used.
- Explanations like "Medication," "Needs Rehab," or "Home Help" do not provide sufficient information to explain a life-threatening emergency.
- Complete all items on the form with pertinent information or write "None." Omissions can delay processing.
- In Item 22, provide a telephone and FAX number on which TDHS can easily reach the DO.
- Photocopy this form as needed.

Revised 02/06