MEDICAID REFERRAL ROUTING SHEET

TODAY'S DATE:		**FROM:**	
TO:		FO CONTACT:	
STATE AGENCY:		FO NAME / CODE:	
ATTENTION:		TELEPHONE:	
FAX #:		FAX #:	

SSI CLAIMANT / RECIPIENT:	
SSN:	
DATE OF BIRTH:	
MEDICAID ID # (IF KNOWN):	

CHANGE OR INFORMATION REPORTED:

☐ **The SSI claimant/recipient transferred resources. Per SI 01150.012, the attached information is required for a Medicaid eligibility determination.**

☐ **The SSI claimant/recipient has a Medicaid trust. Per SI BOS01730.048, the attached information is required for a Medicaid eligibility determination.**

☐ **Other (describe change or information reported):**