A Division of the New York Legal Assistance Group

LegalHealth

Professional Partnership to Promote Well Being

NYLAG

NEW YORK LEGAL ASSISTANCE GROUP

SSI/SSD Application Assistance Project Referral Form for Disabled Patients

(Please note: This initial referral form does not in itself establish representation. A more detailed assessment must be conducted by LegalHealth to determine eligibility for representation.)

Patient Name: _____ Telephone: _____

Address: _____

Social Security Number (optional): _____ Date of Birth: _____

Patient's preferred language: [ ] English [ ] Spanish [ ] Other: _____

1. **Immigration Status**: Due to eligibility restrictions, is the patient a:

   [ ] U.S. Citizen? [ ] Green Card holder (LPR) as of 8/22/1996 or before?

   [ ] Green Card holder since after 8/22/1996 and has a work history?

   If the patient cannot check one of the above boxes, please do not refer them to the project.

2. **Medical Condition**:
   Does the patient have a severe medical problem that prevents them from working, **and** that has lasted for a year or is expected to last for a year?
   [ ] Yes [ ] No

   If the patient cannot answer yes to this question, please do not refer them to the project.

3. **Health + Hospitals Patient:**
   Are the patient's primary conditions treated at this or another HHC hospital?
   [ ] Yes [ ] No

   If the patient is not a Health + Hospitals patient, please do not refer them to the project.

Name and Telephone # of person making referral: _____

To refer a patient who meets the above criteria, please email this completed form to SSAapplication@nylag.org or fax to the attention of the "SSA Application Project" at 212-714-7888.