Clear Form

COUNTYWIDE BENEFITS ENTITLEMENTS SERVICES TEAM (CBEST) REFERRAL FORM

Referral Date: _____

PRE-SCREENING: CBEST PROGRAM ELIGIBILITY*			
Is the client interested in applying for SSI, SSDI, CAPI?	Yes:☐	No:☐	
Is the client currently Homeless or at risk of homelessness? (Please check ONE below)			
Homeless (currently NOT housed)	Yes:☐	Total Number of Months Homeless:_____	
At risk of homelessness (currently housed)	Yes:☐	No:☐	

CLIENT IDENTIFYING INFORMATION			
First Name:	Middle Name:	Last Name:	
Known Aliases:	SSN:	Place of Birth:	DOB:

CLIENT CONTACT INFORMATION			
Mailing Address:			
If no address, where is client most likely to be found?			
City:	State:	Service Planning Area (SPA):	Zip Code:
Primary Phone:	Alternate Phone:	Email Address:	

INITIAL SCREENING OF CLIENTS FOR SSI, SSDI, CAPI BENEFITS ELIGIBILITY		
Has the client applied for SSI or SSDI as an adult (18+)?	Yes:☐	No:☐
If Yes, please add type of last application and disposition below.		
☐SSI Application Date: _____	☐SSDI Application Date: _____	
Disposition:	Disposition:	
☐Approved ☐Pending	☐Approved ☐Pending	
☐Denied, when? _____ If appealed, when? _____	☐Denied, when? _____ If appealed, when? _____	
☐Unknown	☐Unknown	
Has the client served in the U.S. Armed Forces?	Yes:☐	No:☐
Has the client been incarcerated in the last year? (Response does not affect eligibility)	Yes:☐	No:☐
Is the client a U.S. Citizen? (Response does not necessarily affect eligibility)	Yes:☐	No:☐
If No, Does the client have proof of their lawful immigration status?	Yes:☐	No:☐ Doesn't Know:☐

If Yes, Please check below what proof the client has and provide the status of the document.

☐Lawful Permanent Residents (LPR)/Green Card	☐Current	☐Expired (Exp. Date:_____)	☐Other:_____
☐Visa	☐Current	☐Expired (Exp. Date:_____)	☐Other:_____
☐Work Permit	☐Current	☐Expired (Exp. Date:_____)	☐Other:_____
☐Other:_____	☐Current	☐Expired (Exp. Date:_____)	☐Other:_____

What is/are the main health impairment(s) expected to last more than 1 year that the client feels makes them unable to work?

Please list below.

Physical Health: _____

Is the client currently receiving treatment for the listed physical allegations above? Yes: ☐ No: ☐ Don't Know:☐

Mental Health: _____

Is the client currently receiving treatment for the listed mental health allegations above? Yes: ☐ No: ☐ Don't Know:☐

What is the client's language preference(s)?

REFERRER INFORMATION	
Referring Agency and/or Facility:	
Referrer Name & Title:	
Referrer Phone:	Referrer Email:

Please send the referral to DHS CBEST Admin Team via:

Fax: (213) 482-3395 or

Email: cbestreferral@dhs.lacounty.gov

CHAMP ID#:_____

**Please note: The information contained herein reflects eligibility criteria for the CBEST Program ONLY and does not reflect eligibility criteria from the Social Security Administration. The information in this document is not intended to convey or constitute legal advice on potential eligibility for government benefits.*