



Child & Adolescent Supplemental Security Income Program Referral

Before completing this form, please ask enrollee/caregiver if enrollee has active SSI. If yes, do not complete referral form and refer enrollee/caregiver to contact DHCF – Division of Children's Health Services at 202-442-5957 or dchs@dc.gov.

BENEFICIARY

Last Name:	First Name:	Birth Date:	Gender: ☐ M ☐ F
Beneficiary Address:	City:	ST:	ZIP:
Medicaid ID:	Current Medicaid Plan: ☐ ACDC ☐ MFC ☐ AMG ☐ FFS		
Parent Last Name:	First Name:	Address (If different from beneficiary's address):	Phone Number:
Parent Last Name:	First Name:	Address (If different from beneficiary's address):	Phone Number:
Submitter's Email: _____			
Please provide additional contact information if the submitter is not the direct contact for follow up as needed for Comagine request for information (RFI).			
Name: _____			
Address: _____			
Phone Number:	Fax:	Email:	

REFERRING PROVIDER

Last Name:	First Name:	Street Address:	City:	ST:	ZIP:
Telephone Number:	Fax Number:	Email Address:			

DIAGNOSIS FOR CASSIP REFERRAL (Attach supporting documentation)

Providers, please refer to the [Disability Evaluation Under Social Security](#) (Blue Book) for guidelines on diagnosis and required documents.

LIST OTHER DIAGNOSIS

CLINICAL SYNOPSIS (Attach documentation and include justification for referral)

PROVIDER ATTESTATION (for beneficiary less than 18 years of age)

☐ By checking this box, I attest that the parents listed on this form has given consent to complete CASSIP referral form for the beneficiary.

PROVIDER SIGNATURE:

DATE:

SUBMISSION TO DHCF AUTHORIZED AGENT – COMAGINE

This form and the required documents (as applicable) must be completed and uploaded by the provider into [Comagine portal](#), or by fax 1-800-731-2314 or email – DCCASSIPSubmission@comagine.org. Using Comagine Portal is the preferred method of submission because it allows providers to view updates such as Comagine request for information (RFI) and referral status.