

COUNTYWIDE BENEFITS ENTITLEMENTS SERVICES TEAM (C.B.E.S.T) HOSPITAL/CLINIC REFERRAL FORM



Referral Date:			Inpatie	ent Ou	utpatient
	PRE-SCREENING: (CBEST PROG	RAM ELIGIBILITY*	:	
Is the client interested in applying	g for SSI, SSDI, CAPI, or Vet	terans benef	its? Yes:	No:	
Is the client currently Homeless of	_				
Homeless (currently NOT housed			Total Number of	Months Hon	neless:
At risk of homelessness (current					No:
	CLIENT IDEN	ITIFYING INF	ORMATION		
First Name:	Middle N	ame:	Last Name		
Known Aliases:	SSN:		Place of Birth:		DOB:
	CONTA	CT INFORM	ATION		
Mailing Address:					
If no address, where is client mo	st likely to be found?				
City:	State:	Servi	ice Planning Area(SPA):		Zip Code:
Primary Phone:	Alternate Phone:	I	Email Address:		1
INITIAL SCR	EENING OF CLIENTS FOR SS	SI, SSDI, CAP	I, OR VETERANS E	BENEFITS ELIC	GIBILITY
Have you served in the U.S. Armed Forces?			,	Yes:	No:
Have you been incarcerated in the last year? (does not affect eligibility					
U.S. Citizen? (does not necessarily affect eligibility)				Yes:	No:
What is/are the main health imp Please list below.			i year that the th	ent reels mak	es them unable to work:
	l health disabilities listed ab			vice? Yes:	No:
	REFERRING HOSI	PITAL/CLINIC	INFORMATION		
Referring Hospital/Clinic:			Staff Name/Title:		
Staff Phone Number:			Staff Email:		
Alternate Staff Name:	rnate Staff Name: Phone		Email:		
Please send the referral to DHS CE Fax: (213) 482-3395 or	BEST Admin Team via:			СНАМ	1P 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.

Email: cbestreferral@dhs.lacounty.gov