

TO: SOCIAL SECURITY ADMINISTRATION / **LA CROSSE OFFICE**

FAX #: **608-784-7072**

FROM: _____
**Richland County Health & Human Services
Health, Aging & Disability Resource Center**

DATE: _____

This form can be used to obtain information from your Social Security Administration branch office. This type of information can be used in part to help identify if the person you are screening meets target group criteria. The highlighted areas should be replaced with information specific for your agency prior to using the form.

According to the records of the Social Security Administration for:

_____, _____,
Name SSN

the primary disability diagnosis is: _____.
Code #

Secondary diagnosis is: _____.
Code #

Signature of SSA Representative Date

Title

After completing, FAX this form to **608-647-8962.**

Thank you.

**Health, Aging & Disability Resource Center, 181 W. Seminary St., Richland Center, WI 53581
Phone: 608-647-4616 Toll Free: 1-877-641-4616**