MISSOURI DEPARTMENT OF SOCIAL SERVICES
FAMILY SUPPORT DIVISION

CLAIM REFERRAL

CASE NAME

PREVIOUS REFERRAL MADE ☐ YES ☐ NO	DATE
DCN	SOCIAL SECURITY NUMBER
CROSS REFERENCE CASE NAME	DCN

Claims Needed On:	**Apparent Period of Overpayment/Overissuance:**
1. ☐ AFDC/TA	1. ______________ TO ______________
2. ☐ Food Stamps	2. ______________ TO ______________
3. ☐ Other (Specify) ______________	3. ______________ TO ______________

THRESHOLDS FOR ESTABLISHING FOOD STAMP CLAIMS

PARTICIPATING EUs			**NON-PARTICIPATING EUs**		
AE	IHE	SPV/IPV	AE	IHE	SPV/IPV
$70	$70	$0	$400	$400	$0

Time frames for claims: AE-Calculate back no more than twelve months including the month of discovery. IHE-Calculate back no more than twenty-four months including the month of discovery. SPV-Calculate back fro a period up to seventy-two months including the month of discovery. Refer all claims as result of a hearing, OA report, QC report & duplicate issuance.

ALL CASE ADJUSTMENTS MUST BE COMPLETED TO SUBMITTING CR-1

DATE CLAIM DISCOVERED	HOW DISCOVERED

Claim Referred Due To:

☐ Q.C. Report	☐ DI-1
☐ Hearing Decision	☐ Agency Error
☐ Client Error	☐ Other (specify) ______________

Reason for Referral: Briefly explain cause of overpayment/overissuance or ineligibility. **Please attach copies of all verifications** (i.e.: IM-12, IMES, IM-16, signed applications and review forms for claim period, or other documentation).

ES SIGNATURE	COUNTY NUMBER	LD	DATE
SUPERVISOR SIGNATURE			DATE