



Ohio Network for Innovation

1 Avalon Road
Mount Vernon, OH 43050
Fax: 740-722-7227

Referral Information

Who is making this referral?:	Date:
Organization:	Phone:
Email:	

Enrollment Information:

Last Name:	First Name:	MI:	
Address:	Apt:		
City:	State:	Zip:	County:
Phone Number:	Email:		
SS#:	<input type="checkbox"/> INCLUDE COPY OF CURRENT STATE ID		<input type="checkbox"/> INCLUDE COPY OF SOCIAL SECURITY CARD
DOB:	<input type="checkbox"/> INCLUDE COPY BIRTH CERTIFICATE		
Diagnosis:	Diagnosis onset date:		
Does the Claimant have a Court Appointed Legal Guardian?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<input type="checkbox"/> INCLUDE COPY OF GUARDIANSHIP LETTER		If yes, enter the guardian's information below:	
Name:			
Address:	Phone Number:		
Email:			

Enter the names, relationship, DOB of any other people who live with the claimant below.

Name	Relationship	DOB

Describe the setting where the person lives? (Examples: Alone or with a relative):

Type of Benefits: SSDI SSI Wages STABLE Other:

Does the Claimant already have a payee in place? Yes No

If yes, please explain the reason for the change:

If no, please enter physician's information below.

Name:

Address:

Phone number: Fax Number:

Authorization for STABLE or Wages Fund Management:

By checking this box, you give consent for ONI to manage funds for STABLE and/or Wages accounts. A signature from the individual or their guardian is required below to confirm authorization.

Signature: _____ Date: _____

Please submit completed referral forms and supporting documentation to:

financesupport@ohionetworkforinnovation.com