

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: <input type="checkbox"/> SSDI <input type="checkbox"/> SSI <input type="checkbox"/> Wages <input type="checkbox"/> STABLE <input type="checkbox"/> Other:		

Does the Claimant already have a payee in place? <input type="checkbox"/> Yes <input type="checkbox"/> 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:

<input type="checkbox"/> 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