PARTNERS FOR KIDS | dayton children's

Supplemental Security Income (SSI) Referral Form

Please fax this completed form to (614) 938-8515 or email to SSI@nationwidechildrens.org.
Please allow ten business days for us to process this request.

Today's Date: _______________

Provider Contact Information (required)

Referring Provider: ____

Practice / Clinic Name: _____________________________________

Has anyone discussed SSI with the family already? ___Yes ___No

[Select One]

☐ My practice / clinic would like to make the initial phone call with the patient to start the application process. Please contact this staff member on our team:

Name: ______________________ Phone Number: ______________________

☐ Nationwide Children's Hospital / Partners For Kids has permission to make the initial phone call with patient to start the application process

Patient Information

[Optional for NCH Referrals] Place Patient Sticker Here

Parent/Caregiver Name: _______________________________________

Current Phone Number: _______________________________________

If you do NOT have a Patient Sticker, please provide as much of this information as possible:

Health Plan: __________________________ Health Plan Member ID #: _______________________

Patient's Name: ____

Patient's Date of Birth: _______________________________________

Does Patient Need a Translator? ___Yes ___No

If Yes, What Language? __________________________________

Anything else that's helpful to know about this referral: ____

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