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: _____

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

Patient Information

[OPTIONAL] 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: _____