Otter Tail Health Care Services LLC

441 Old Highway NW Suite 213 New Brighton, MN
55112

PHONE: 612-87611-44| FAX: 612-278-2121

EMAIL: lhashi@ottertailhealthcare.org

SSI/SSDI Referral Form

Individual's Name _____

Age _____

Address _____

Phone Number (s) _____

Email _____

INDIVIDUAL NEEDS HELP WITH:

☐ Initial Application ☐ Reconsideration

☐ Filing hearing request ☐ Hearing requested, needs help with hearing representation

☐ Benefits terminated, needs help with appeal ☐ Other _____

REFERRAL AGENCY: _____ _____ _____ _____

Referring Person: _____ _____ _____

Phone and Email:_____ _____

☐ Referring Person: I talked to the above individual who asked that you call them about their disability case.

Date:_____ _____ Signed:_____ __

OR

☐ Individual: Please call me about my disability case.

Date: _____ Signed:_____ __