Disability Benefit Solutions, LLC

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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:_____ __