



Independent Management Services

Providing Human Services to Families in Southern Minnesota

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SSA Referral Form

Name *(first, middle, last)*: _____

Date of Birth: _____ Social Security Number: _____

Address: _____ Best Contact Method: Phone ☐ Email ☐ In Person ☐

Other ☐ _____

Email: _____ Phone: _____

Program: MFIP ☐ MA ☐ SNAP ☐ GA ☐ GRH ☐ Other ☐ _____

Individual Needs Help With:

Initial application ☐ Appeal ☐ ALJ Hearing ☐ Other ☐

Disabling Condition(s): _____

Referral Agency: _____

Referring Person: _____

Phone: _____ Email: _____