SELF-RELIANCE

HOME & COMMUNITY BASED SERVICES
REFERRAL FORM

Customer Name: _____ Date of Birth: _____ Age: _____

SS#: _____ Address: _____ Phone #: _____

Title XIX #: _____ Type of Waiver Service Requested: _____

County of Legal Settlement: _____ Court Committed? _____

If Address is different from above, please put appropriate address: _____

_____

What type of environment does consumer reside in? _____

_____

How many people will be living there? (Please tell relationship): _____

_____

Is consumer currently at risk of being institutionalized? _____

If so, where? _____

t type of daily living skills does the consumer need? (bathing meal planning and preparation, money management, edication management, coping skills, adaptive skills, attendance, task completion, appropriate behavior, greater dependence, improvement of self-help, socialization).

Is the consumer involved in any other services or activities? _____

If so what are they? _____

What services does the consumer want?

A. Supported Community Living _____
   If so minimum hours needed? _____
B. Respite _____
   If so minimum hours needed? _____
C. Home Habilitation _____
   If so Minimum hours needed? _____

Current Medications: _____

_____

_____

stive devices: (crutch, cane, glasses, hearing aide, lift, etc.) _____

_____

Medical interventions: (breathing apparatus, G-Tube, catheter, Special dietary needs, etc.)

_____

_____

List any unusual or maladaptive behaviors: _____

_____

_____

_____

_____

_____

Does the consumer have a guardian? _____

If so name/phone #/address: _____

Does the Consumer have a payee? _____

If so name/phone #/address: _____

Timelines for processing the application? _____

Referral process the provider must follow when the provider chooses not to admit the consumer:

Send formal letter of decision to:

_____ Facility

_____ Case Manager

_____ Family/Guardian

_____ Advocate

Service Coordination (activities designed to assist individuals and families locate, access and coordinate a network of supports and services within the community: _____

_____

_____

_____

_____

_____

Referral Source Signature

_____

Date

_____

(Self-Reliance)

Notification process for each admission decision. _____ approved _____ needs higher level of care

_____ needs lower level of care _____ no adequate funding _____

Notification approval/non-approval date_____ Notification sent by (Personnel)_____

SELF-RELIANCE

HOME & COMMUNITY BASED SERVICES
REFERRAL FORM

Customer Name: _____ Date of Birth: _____ Age: _____

SS#: _____ Address: _____ Phone #: _____

Title XIX #: _____ Type of Waiver Service Requested: _____

County of Legal Settlement: _____ Court Committed? _____

If Address is different from above, please put appropriate address: _____

_____

What type of environment does consumer reside in? _____

_____

How many people will be living there? (Please tell relationship): _____

_____

Is consumer currently at risk of being institutionalized? _____

If so, where? _____

t type of daily living skills does the consumer need? (bathing meal planning and preparation, money management, edication management, coping skills, adaptive skills, attendance, task completion, appropriate behavior, greater dependence, improvement of self-help, socialization).

Is the consumer involved in any other services or activities? _____

If so what are they? _____

What services does the consumer want?

A. Supported Community Living _____
   If so minimum hours needed? _____
B. Respite _____
   If so minimum hours needed? _____
C. Home Habilitation _____
   If so Minimum hours needed? _____

Current Medications: _____

_____

_____

stive devices: (crutch, cane, glasses, hearing aide, lift, etc.) _____

_____

Medical interventions: (breathing apparatus, G-Tube, catheter, Special dietary needs, etc.)

List any unusual or maladaptive behaviors: _____

Does the consumer have a guardian? _____
If so name/phone #/address: _____

Does the Consumer have a payee? _____
If so name/phone #/address: _____

Timelines for processing the application? _____

Referral process the provider must follow when the provider chooses not to admit the consumer:
Send formal letter of decision to:

_____ Facility
_____ Case Manager
_____ Family/Guardian
_____ Advocate

Service Coordination (activities designed to assist individuals and families locate, access and coordinate a network of supports and services within the community: _____

_____
Referral Source Signature

_____
Date

(Self-Reliance)
Notification process for each admission decision. _____ approved _____ needs higher level of care
_____ needs lower level of care _____ no adequate funding _____

Notification approval/non-approval date_____ Notification sent by (Personnel)_____

SELF-RELIANCE

HOME & COMMUNITY BASED SERVICES
REFERRAL FORM

Customer Name: _____ Date of Birth: _____ Age: _____

SS#: _____ Address: _____ Phone #: _____

Title XIX #: _____ Type of Waiver Service Requested: _____

County of Legal Settlement: _____ Court Committed? _____

If Address is different from above, please put appropriate address: _____

_____

What type of environment does consumer reside in? _____

_____

How many people will be living there? (Please tell relationship): _____

_____

Is consumer currently at risk of being institutionalized? _____

If so, where? _____

t type of daily living skills does the consumer need? (bathing meal planning and preparation, money management, edication management, coping skills, adaptive skills, attendance, task completion, appropriate behavior, greater dependence, improvement of self-help, socialization).

Is the consumer involved in any other services or activities? _____

If so what are they? _____

What services does the consumer want?

A. Supported Community Living _____
   If so minimum hours needed? _____
B. Respite _____
   If so minimum hours needed? _____
C. Home Habilitation _____
   If so Minimum hours needed? _____

Current Medications: _____

_____

_____

stive devices: (crutch, cane, glasses, hearing aide, lift, etc.) _____

_____

dical interventions: (breathing apparatus, G-Tube, catheter, Special dietary needs, etc.)

List any unusual or maladaptive behaviors: _____

Does the consumer have a guardian? _____
If so name/phone #/address: _____

Does the Consumer have a payee? _____
If so name/phone #/address: _____

Timelines for processing the application? _____

Referral process the provider must follow when the provider chooses not to admit the consumer:
Send formal letter of decision to:

- _____ Facility
- _____ Case Manager
- _____ Family/Guardian
- _____ Advocate

Service Coordination (activities designed to assist individuals and families locate, access and coordinate a network of supports and services within the community: _____

_____
Referral Source Signature

_____
Date

(Self-Reliance)
Notification process for each admission decision. _____ approved _____ needs higher level of care
_____ needs lower level of care _____ no adequate funding _____

dification approval/non-approval date_____ Notification sent by (Personnel)_____