

Intellectual & Developmental Disabilities Referral Form



Applicant Information

Name:		Call Date:	
Other names/aliases:			
Date of Birth:	Gender:	Language spoken by client:	
Diagnosis:			
Physical Address:		Mailing Address:	
Phone:		2 nd Phone:	
Does the applicant receive SSI?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Health Insurance:	<input type="checkbox"/> OHP <input type="checkbox"/> Other:
Agency:		Agency:	
Contact:		Contact:	
Address:		Address:	
Phone:		Phone:	

Referral Source

Do you have permission from the applicant or legal guardian to make this referral?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have permission from the applicant or legal guardian to schedule an intake?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Agency: Contact:	Address:	
Phone:	Email:	

Legal Guardian Information

Name/Relationship:	Language spoken in the home:
Physical Address:	Mailing Address:
Phone:	Email:

INTERNAL USE ONLY

Assigned CSS:	Intake Date:	Intake Time:	Intake Type:	<input type="checkbox"/> OV	<input type="checkbox"/> HV
Address:					
Interpretation Company:		Confirmation Code:			
Health and Safety Questions:					