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**Referral Form for Services and Supports**

**Referral Date:** 4/25/2018 **Time: 3:53 PM** **Agency Name:**      **Staff Person Taking Referral:**

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| person making the referral: |
| Name: |
| Phone: (   )        Cell  Home  Work |
| E-mail: |
| Relationship to Individual in need of supports and services: |

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| individual in need of services and supports | | | | | |
| Name: | | | Age: | Date of Birth: | |
| Address: | | City: | | | Zip Code: |
| County: | Phone: (   )        Home  Work  Cell | | | | |
| E-mail: | | | | | |
| If not English-speaking, preferred language: | | | | | |
| Do you live alone?  Yes  No | | Safety issues (i.e. dogs)?  Yes  No  Please describe: | | | |
| If not a home residence, please indicate the name and type of facility where the Individual is located. | | | | | |
| Facility Name: | | | | | |
| Facility Address: | | | | | |
| Assisted Living  Supportive Living Program  Long-term Care Facility (Nursing Home)  Hospital  Hospice Facility  Other: Name: | | | | | |

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| Does the individual have a spouse?  Yes  No | If yes, Spouse Name: | |
| Is spouse in need of services and supports?  Yes  No | | Age of spouse? |
| Is there a friend/family caregiver or emergency contact that needs to be contacted?  Yes  No | | |
| If yes, provide contact information (if known): | | |

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| Does the individual have any of the following? |
| Legal Guardian  Yes  No  Unknown |
| Representative Payee  Yes  No  Unknown |
| Power of Attorney for Health  Yes  No Unknown |
| Power of Attorney for Financial  Yes  No Unknown |
| If yes, provide contact information (if known): |
| Is there a friend/family caregiver or emergency contact that needs to be contacted?  Yes  No |
| If yes, provide contact information (if known): |
| Is there any other individual at this residence that needs services and supports?  Yes  No |
| **NOTE:** If yes, complete a separate referral form if 60 or over. If under 60, refer to the proper state agency. |
| Name of other individual (if known): |
| Age of other individual (if known): |

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| Health Information: |
| Does the Individual have: Hearing loss?  Yes  No  Unk. Vision Issues?  Yes  No  Unk. |
| If yes, preferred method of communication (i.e., Interpreter, TTY Relay Services or Braille Assistance): |
| Has the Individual been told by a health care professional that they have any of the following? |
| Alzheimer’s or any other type of dementia?  Yes  No  Unknown |
| Mental Health Illness?  Yes  No  Unknown |
| Physical Disability?  Yes  No  Unknown |
| Intellectual/Developmental Disability?  Yes  No  Unknown |
| Brain Injury (i.e., stroke, head injury, aneurysm)?  Yes  No  Unknown |

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| Additional information regarding the individual in need of supports and services |
| Reason for Referral (general concerns): *Please provide any additional information regarding the Individual in need of supports and services that may be helpful.* |
| Does the Individual receive any supports and services now?  Yes  No  If yes, type of supports and services are received: |
| Is the Individual experiencing any problems with the current supports and services?  Yes  No  Please explain: |
| Has the Individual or spouse served in the military?  Yes  No |
| Is the Individual aware of the referral?  Yes  No  Unknown |
| Is the Individual in immediate danger?  Yes  No  Unknown  Explain: |
| Is the Individual in need of immediate assistance?  Yes  No  Explain: |
| Does the Individual want someone else to be present during the home visit?  Yes  No  If yes, who: |
| What would be the best time and method to contact the Individual (if known):  Time:  Phone: (   )  E-mail: |