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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 [ ]  NoPlease 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 [ ]  NoIf yes, type of supports and services are received:       |
| Is the Individual experiencing any problems with the current supports and services? [ ]  Yes [ ]  NoPlease 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 [ ]  UnknownExplain:       |
| Is the Individual in need of immediate assistance? [ ]  Yes [ ]  NoExplain:       |
| Does the Individual want someone else to be present during the home visit? [ ]  Yes [ ]  NoIf yes, who:       |
| What would be the best time and method to contact the Individual (if known):Time:      Phone: (   )      E-mail:       |