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**9701 Metropolitan Court, Suite C, North Chesterfield, VA 23236**

**Referral & Pre-Screening Assessment**

**Identifying Information (please complete entire form) Initial Contact Date:\_\_\_\_\_\_**

**Requesting Service:** Community Engagement Sponsored Residential

 Crisis Stabilization Services Self Pay/ Non-Waiver Based I/DD Services

Individual’s name: DOB: Age:

SS#: Gender: Race:

Medicaid **#:** Phone: \_\_\_\_\_\_

Address: City: State: ZIP:

**Legal Status: (PLEASE SELECT ONE)**

 **SELF COURT APPOINTED GUARDIAN POWER OF ATTORNEY**

**Legal Guardian:** Phone**:**

**Person making Referral:**

Phone: Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Case Manager Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CSB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Preliminary Dx:** **Secondary Dx**

**Current/Presenting Problems:** (*presenting needs/situation including psychiatric and medical problems, current medications, and history of medical care*)

Reason for referral:

**Mandatory Requirements** *(Both must be checked in order for individual to be eligible for services):*

□ The individual is enrolled in Medicaid

□ The individual has a primary diagnosis of developmental disability.

□ The individual currently has a DD Waiver

Disposition: Admitted \_\_\_\_ Did not meet criteria \_\_\_\_\_ Referred to other services\_\_\_\_ Declined Services \_\_\_

Staff Completing Intake: ­­­­­­­­­­­­­­­­­ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_