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

Individual’s name: DOB: Age: School:

SS#: Gender: Race:

Medicaid **#:** HMO name/MEMBER#:

Phone: Address: City: State: ZIP:

**Parent/Guardian:** Phone**:**

**Person making Referral:** Phone:

**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 community engagement):*

□ The individual is enrolled in Medicaid

□ The individual has a primary diagnosis of developmental disability.

□ The individual current has a DD Waiver

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

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