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**UBU Synergy Support Referral**

Please fill out to the best of your ability and return to alyssa.ruff@ubusupport.org

**Attach** the client's **Assessment Summary and Support Plan** when submitting the referral.

Our NPI is 1417595463

Date:

Case Manager:

Case Manager Email:

Case Manager Phone #:

**Client Information**

Client Name:

Phone #:

Address:

DOB:       Primary Diagnosis and Codes:

PMI:       Waiver Type:       Current Waiver Span:

County Case Number:       Financial Worker phone number:

Approximate hours per week of service needed:       Client Availability:

Service choice(s):

|  |  |  |  |
| --- | --- | --- | --- |
| [ ]  24-hour Emergency Assistance | [ ]  IHS with Training  | [ ]  Housing Stabilization Services Consult  | [ ]  Housing Stabilization Services Transition & Sustaining |

Other service providers to assist with continuity of care:

Special Considerations and Needs:

Primary Spoken Language/ASL/Cultural Preference: