

REFERRAL FORM



FUNDING:

SERVICE:

- Medicaid Waiver (indicate type:)
- DARS

- Individual Supported Employment
 - Situational Assessment
 - Job Development
 - Placement & Training
- Benefits Planning
- Workplace Assistance

REFERRAL SOURCE:

Referral Agency: Case Manager:

Email: Telephone/Fax:

INDIVIDUAL DATA:

Name: S.S. #:

Address:

Telephone: Date of Birth:

Medicaid number: Other insurance (if applicable):

Primary diagnosis and code:

Secondary diagnosis and code:

ISP dates (if applicable): Quarterly dates (if applicable):

Does the client have a legal guardian? If so, please provide name and address:

Notes:

Please fax the following information with the referral form:

- SIS (Waiver)
- Risk Assessment (Waiver)
- VIDES (Waiver)
- Psychological Report/Medical Information (All)
- Applicable protocols (if applicable) including behavior support plan (Waiver)
- Documentation that no other funding is available for supported employment services
- (All) Guardianship order (if applicable) (All)

RETURN TO: Richard Richmond, Program Coordinator, rrichmond@employmentadvocates.org

Employment Advocates Group: 7340 Heritage Village Plz, Ste 102 , Gainesville , VA 20155

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