REFERRAL FORM

EMPLOYMENT ADVOCATES GROUP

FUNDING:	SERVICE:
☐ Medicaid Waiver (indicate type:)	☐ Individual Supported Employment
☐ DARS	☐ 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: 7001 Heritage Village Plz, Ste 245 · Gainesville 20155 · VA · 20111

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