REFERRAL FORM

EMPLOYMENT ADVOCATES GROUP

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: Theo Rucker-Abilla, Program Coordinator, theo@employmentadvocates.org

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