REFERRAL FORM

MEDICAID WAIVER:	SERVICE:
☐ Medicaid Waiver (indicate type: _____) ☐ DARS ☐ Private Pay☐ CSB Local Funding	☐Supported Employment (Individual) ☐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: _____ Quarterly dates: _____

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)

Office Use: Case #	Counselor:	Signature:	Date:

Employment Advocates Group

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