Revive Living Solutions

Referral Form

Select Service Type
☐ Housing Transition ☐Housing Stabilization ☐Housing Consultation ☐Other
"Choice Referrals" Meaning we accept clients that have their own staff. Does the client have their own staff? ☐ YES ☐ NO

INDIVIDUAL'S INFORMATION			
Full Name:	**DOB** (mm/dd/yyyy): / /	**Gender:** ☐ Male ☐ Female ☐ Non-binary	
Address:	**City:**	**State:**	**Zip:**
Phone #:	**County:**	**PMI #:**	**Other:**
Waiver Type/Payment Source: ☐ DD ☐ CADI ☐ CAC ☐ AC ☐ Private Pay ☐ Other (list):			
Is their Medical Assistance and waiver plan currently active? ☐ Yes ☐ No	**What is the renewal date:**		

Number of hours per week of services being requested:

NPI #: A407158300

Availability:
Please fill out the days of the week, and available times for this person to work with staff. This information is necessary so that we can have staffing available.

Days	Sun	Mon	Tues	Weds	Thurs	Fri	Sat
Times							

When would you like to start services? / /

Guardianship Status: ☐ Self ☐ Other (list name & contact info):

CASE MANAGER'S INFORMATION			
Case Manager Name:			
Agency:	**Phone #:**	**Fax #:**	
Address:	**City:**	**State:**	**Zip:**
Email:			

Please fill out the form with as much detail as possible and return with a copy of the most current Coordinated Service and Support Plan (CSSP) or the Housing Focused Center Plan

Send the completed referral to info@revivelivings.org