

Referral Questionnaire

Name of Individual: _____ Sex: _____

Date of Birth: _____ Age: _____ Date of Referral: _____

Parents/Guardian Name: _____

Address: _____

Phone Numbers: Home: _____ Cell: _____ Work: _____

Email: _____

Name of person making referral: _____ Relationship _____

Address (if different than above): _____

Phone Numbers: Home _____ Cell: _____ Work: _____

Email: _____

Please check all the services of interest to you at the current time.

- | | |
|---|---|
| <input type="checkbox"/> Day School | <input type="checkbox"/> Main Campus Adult Training |
| <input type="checkbox"/> Main Campus Residential (ICF/MR) | <input type="checkbox"/> Employment Option Center |
| <input type="checkbox"/> Community Homes | <input type="checkbox"/> Respite Program |

School District: (if interested in school program) _____

Supports Coordination Unit: _____

Address: _____

Supports Co-ordinator: _____ Phone Number _____

Does the person have wavier funding: Yes _____ No _____

Type of Wavier _____ Waiver Funding Level: \$ _____

Comments: _____

