

# Inspiring Hope / Fostering Growth

## Referral Questionnaire

Name of individual: \_\_\_\_\_ Gender: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Date of referral: \_\_\_\_\_

Parents/Guardian Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Numbers: Home: \_\_\_\_\_ Cellular: \_\_\_\_\_ Work: \_\_\_\_\_

Email Address: \_\_\_\_\_

Name of person making referral: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address (if different than above): \_\_\_\_\_

Phone Numbers: Home: \_\_\_\_\_ Cellular: \_\_\_\_\_ Work: \_\_\_\_\_

Email Address: \_\_\_\_\_

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

\_\_\_\_\_ Day School

\_\_\_\_\_ Main Campus Adult Training

\_\_\_\_\_ Main Campus Residential (ICF/MR)

\_\_\_\_\_ Employment Option Center

\_\_\_\_\_ Community Homes

\_\_\_\_\_ Respite Program

School District (if interested in school programs): \_\_\_\_\_

Supports Coordination Unit: \_\_\_\_\_

Address: \_\_\_\_\_

Supports Coordinator: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Does the person have waiver funding? Yes \_\_\_\_\_ No: \_\_\_\_\_

Type of waiver: \_\_\_\_\_ Waiver Funding Level: \_\_\_\_\_

Comments: \_\_\_\_\_

