



Consumer Referral Application Form

For: _____
Service Type: (Residential or Supported Employment)

Consumer Name _____ Date _____

Address _____

Phone (Home) _____ (Work) _____ Sex _____

Soc. Sec. Disab. Insur. (SSDI) _____ Supp. Sec. Insur.(SSI) _____

Medicaid # _____ Medicare # _____

Other Insurance _____ Policy # _____

Source of Referral _____

Date of Initial Vendor Contact _____

Reason for Referral _____

Date of Birth _____ Birth Place _____

Primary Diagnosis / Date _____

Other / Secondary Diagnosis / Date _____

Are you a United States Citizen? _____ Race _____

Criminal Justice Status (if any) _____

Legal Guardian (Court Appointed) _____ () N/A

Address _____

Phone (Home) _____ (Work) _____

Primary Language _____ Secondary Language _____





Family Composition / Others who Reside with You (relationships)

Father _____ Occupation _____

Address _____

Phone (Home) _____ (Work) _____

Mother _____ Occupation _____

Address _____

Phone (Home) _____ (Work) _____

Siblings _____

_____ Ages _____

Other Significant Support Systems _____

Family/Emergency Contacts (other than parent or doctor)

Name _____ Relationship _____

Address _____

Phone (Home) _____ (Work) _____

Name _____ Relationship _____

Address _____

Phone (Home) _____ (Work) _____

Day Support Funding Source:

Medicaid State Plan Option _____ Medicaid Waiver _____ CSB _____

Other _____





Consumer Preferences and Behavioral Information

Residential Preference: Group Home _____ Apartment Living _____

Vocational / Employment Interests (Type of Work): _____

Special Dietary Needs _____

Current Living Arrangement _____
(Home, Apartment, Group Home, Institution, Etc.)

Name of Case Manager _____ Phone Number _____

Name of DRS Counselor _____ Phone Number _____

Currently Attends Day Program Yes _____ No _____

Describe any concerns or issues that may affect your daily participation in a day support / employment services program

Communication:

(Circle yes or no for each item)

Uses Sounds / Gestures: Yes/No
Uses Key Words / Signs: Yes/No
Speaks Clearly: Yes/No
Intelligible to Strangers: Yes/No

Transportation:

(Circle yes or no for each item)

Transportation Available: Yes/No
Lives on Bus Route: Yes/No
Family Available to Transport: Yes/No
Provides own Transportation: Yes/No



Behavioral History:

History of oppositional/ defiant behavior, ignores rules or regulations?	Yes/No
History of Wandering / Leaving for long periods of time / Running away?	Yes/No
Difficulty respecting boundaries/ taking others' belongings?	Yes/No
Removes or tears off clothing?	Yes/No
Displays sexually inappropriate behavior (eg. inappropriate touching)?	Yes/No
History of use of profane or hostile language?	Yes/No
History of physical violence to self or others?	Yes/No





Please Attach the Following Information to the Referral Form and Submit to Job Discovery Inc.

1. Psychological Evaluation
2. Social History
3. Current ISP, ICAP
4. Medical History
5. Medication Administered
6. Documentation of Guardianship
7. Record of Immunization / Prevention (Hepatitis, TB test, Flu, Tetanus, etc.)
8. Criminal Background History Report

Please share any comments in the space below or attach any other documents that might be helpful in Job Discovery Inc.'s review of this packet.

Thank you,
Job Discovery Inc.

Person Completing form _____ Title _____ Phone _____

