# Referral for Services

Class member: ☐ Yes ☐ No

Referral Date:

Services Needed:

- ☐ Adult Case Management
- ☐ Adult BHHO Services
- ☐ DLSS/Skills
- ☐ Shared Living
- ☐ Children's Case Management
- ☐ Children's BHHO
- ☐ Community Support Program Center Based
- ☐ 1:1 DSP Home Supports
- ☐ 1:1 DSP Community Supports
- ☐ Personal Support
- ☐ Registered Nurse
- ☐ Homemaker
- ☐ DBT Group
- ☐ Outpatient Therapy

Referral Source:

Referral Source Phone:

Relationship to Individual Needing Service:

Name of Organization:

Email Address:

## Demographics of Individual Needing Services

Name:

Date of Birth:

Address Line 1:

Address Line 2:

City: State:

Zip Code:

Phone Number:

Need Interpreter? ☐ Yes ☐ No

Is it ok to leave message? ☐ Yes ☐ No

Choose Guardian Type:

- ☐ Sole
- ☐ Own (18-21) or Emancipated
- ☐ Shared
- ☐ DHHS Custody

## Legal Guardian

Name:

Address Line 1:

Address Line 2:

City: State:

Zip:

Phone:

## Emergency Contact

Name:

Relationship:

Phone:

## Insurance Information

Insurance Company:

Policy ID #:

Subscriber SSN:

Subscriber Name:

## Other Insurance Information

Insurance Company:

Policy ID #:

What needs can Assistance Plus help you with?

Most Recent psychiatric hospitalization (For Behavioral Health Only)

What other service providers are currently in place?

Are there any current safety risks for the client or our staff around meeting in the clients home?

How did you hear about us?

Please fax and attach current signed and credentialed diagnosis for Behavioral Health or Intellectual Disability referrals.

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