



Service Provider Referral Form In-Home Support

Received: Click or tap to enter a date.

Please complete to the best of your ability. If the information is unknown, please indicate this by writing unknown.

Person making referral:		Agency:	
Member Contact Information			
Member's Name:		Date of Birth: <small>Click or tap to enter a date.</small>	
Address: _____		Age:	
City: _____		Gender:	
State: _____		Preferred Language: If other than English, is a translator required? <input type="checkbox"/> - Yes <input type="checkbox"/> - No	
Phone number:		Relationship status:	
Guardian Information			
Does member have a guardian? <input type="checkbox"/> Yes <input type="checkbox"/> No		Guardian Contact Address: Street: _____ City: _____ State: _____	Guardian Phone Number: () -
Income Type:			
<input type="checkbox"/> Social Security <input type="checkbox"/> SSDI	<input type="checkbox"/> SSI <input type="checkbox"/> Employment Income <input type="checkbox"/> Death Benefits	<input type="checkbox"/> SSIE <input type="checkbox"/> Unemployment- related benefits	
Living Arrangements:			
<input type="checkbox"/> Lives independently <input type="checkbox"/> Lives with family <input type="checkbox"/> Lives with partner/spouse	<input type="checkbox"/> Lives with roommate <input type="checkbox"/> Lives in group home <input type="checkbox"/> Lives in a supported community	<input type="checkbox"/> Lives in Adult Family Home <input type="checkbox"/> Other (specify) - _____	
Housing Type: <input type="checkbox"/> - Owns home <input type="checkbox"/> - Rents home/ apartment/ duplex <input type="checkbox"/> - Rents room <input type="checkbox"/> - Lives with care provider <input type="checkbox"/> - Other, please explain:			
Transportation			
<input type="checkbox"/> - Drives/owns car <input type="checkbox"/> - City bus <input type="checkbox"/> - Bicycle	<input type="checkbox"/> - Walk <input type="checkbox"/> - Cab/taxi service <input type="checkbox"/> - Other (family, roommate, care provider, etc.)		
Natural Support Involvement:			
Contact person/relationship	Address	Phone number	



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Agency Involvement:		
Contact person/agency	Address	Phone number
Legal Involvement:		
Is member protectively placed?		
<input type="checkbox"/> - Yes <input type="checkbox"/> - No		
Does member have active charges against them (misdemeanor/felony)?		
<input type="checkbox"/> - Yes <input type="checkbox"/> - No		
Please Explain:		
Please explain past criminal history (if applicable):		
Please explain any past/ current drug/ alcohol use:		
Medical Conditions (including disability diagnosis):		
List medical conditions:		
- _____		
- _____		
- _____		
- _____		
List of disability diagnosis:		
- _____		
- _____		
- _____		
- _____		
Please list any mental health concerns/ diagnoses:		
Physician (Ophthalmologist, Primary Physician, Dentist, Audiologist, Mental Health Specialists, etc.).		
Physician name	Specialty	Clinic
Medications		
List medications:	Purpose of Medications:	
_____	_____	
_____	_____	



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_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Assistive Devices

Does the member use any devices such as walker, wheelchair, cane, hearing aids, incontinence briefs?

What type of device does the member require?

Behavioral, Legal and Safety Concerns/Issues:

<input type="checkbox"/> Aggressive toward others	<input type="checkbox"/> Recent suicide thoughts	<input type="checkbox"/> Flight risk	<input type="checkbox"/> Outbursts
<input type="checkbox"/> Aggressive toward self	<input type="checkbox"/> Inappropriate language	<input type="checkbox"/> Repetitive behaviors	<input type="checkbox"/> Hyperactive
<input type="checkbox"/> Puts objects in mouth	<input type="checkbox"/> Personal boundaries	<input type="checkbox"/> Pending legal issues	<input type="checkbox"/> Weapons in home
<input type="checkbox"/> Recent self harm	<input type="checkbox"/> Any sexual behaviors	<input type="checkbox"/> Legal involvement	<input type="checkbox"/> Weapons secure
<input type="checkbox"/> Past self harm	<input type="checkbox"/> Sexually acting out	<input type="checkbox"/> (Juvenile Detention, Probation, Parole, Incarceration History).	<input type="checkbox"/> Poor coordination/balance
<input type="checkbox"/> Recent suicide attempts	<input type="checkbox"/> Any drug or alcohol use		
<input type="checkbox"/> Past suicide attempts	<input type="checkbox"/> Drug overdose history		
	<input type="checkbox"/> Destroys property		

Further explain behavioral, legal and safety concerns:

Allergies:

Does the member have allergies? Yes No

Please explain allergy (if applicable):

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Purpose of Referral:

Reason referral is being made:

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Referred By:

Name of Community Resource Coordinator/IRIS Consultant:

Signature of Community Resource Coordinator/IRIS Consultant: _____

Address:

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Phone:	Email:
Name of Family Care or IRIS Agency:	