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SPD:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Individualized Home Supports – Referral Form***

**\**Required lines to fill in below***

**Today’s Date:**

**Name:**

**Type of Referral (Please check which one applies):**

**[ ]  Individualized Home Supports WITH Training**

**[ ]  Individualized Home Supports WITHOUT Training**

**[ ]  Individualized Home Supports WITH Family Supports**

**Please include and email a copy of a current CSSP/CSP along with this referral.**

**Housing Type:** **[ ]  Apartment/Home** **[ ]  Nursing Home** **[ ]  Assisted Living** **[ ]  Group Home/Foster Home** **[ ] Homeless**

**Address:**

**Phone:**

**Email:**

**Primary Disability(ies):**

**Is this person able to meet virtually if needed? [ ]  Yes [ ]  No – If no, what are the barriers?**

**Are there currently any animals living in the home of this referral?** **[ ]  Yes** **[ ]  No** **[ ]  Unsure**

* **If Yes, please identify:**

**Own Guardian/Legal Representative: [ ]  Yes [ ]  No**

**Guardian/Legal Representative Name and Phone Number:**

**Services requesting – please identify what services and areas for outcomes that this consumer would like to or benefit from working on:**

**Any scheduling conflicts to work around? (School/work/treatment/etc.):**

**Are there any specific days or times during the week the person prefers to meet?:**

**County of Residence:**

**Date of Birth:**

**Gender:** **[ ]  Male** **[ ]  Female** **[ ]  Other**

**County Social Worker and Phone Number:**

**County Social Worker Email:**

**Waivered Service:** **[ ]  CADI** **[ ]  DD** **[ ]  TBI** **[ ]  DD/SILS** **[ ]  CDCS** **[ ]  Other**

**Please check if authorizing (all applicable):** [ ]  **In Person Services** [ ]  **Remote Services**

**Hours Authorizing:**

**Preference working with a** **[ ]  Female or** **[ ]  Male staff person or** **[ ]  Either**

**Other Information that would be important to know in regards to this referral:**