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Individualized Home Supports – Referral Form

Today's Date:

Name:

Type of Referral (Please check which one applies):

☐ **Individualized Home Supports WITH 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** ☐ **Assisted Living** ☐ **Group Home/Foster Home** ☐ **Homeless**

Home 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**

If 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:

Gender Preference of Staff: ☐ Female ☐ Male ☐ Either

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