Reach for Resources, Inc.

COMMUNITY LIVING DEPARTMENT
REFERRAL FORM

PLEASE PRINT

DATE OF REFERRAL: _____

PROGRAM(S) REFERRED TO:
(Please indicate Waiver or County Funding) _____

REFERRED BY: _____ RELATIONSHIP: _____

AGENCY/ADDRESS: _____

PHONE: _____ EMAIL: _____

PERSONAL INFORMATION

NAME: _____ DOB: _____ PMI: _____

ADDRESS: _____ CITY/STATE/ZIP: _____

PHONE: _____ ALTERNATE PHONE: _____ GENDER: ◯ MALE ◯ FEMALE

WAIVER ELIGIBLE: ◯ YES ◯ NO TYPE: ◯ DD WAIVER ◯ CADI WAIVER ◯ ELDERLY WAIVER ◯ BI

DOES THIS INDIVIDUAL RECEIVE COUNTY FUNDING?: ◯ YES ◯ NO: Explain _____

IS THIS INDIVIDUAL HIS/HER OWN GUARDIAN? ◯ YES ◯ NO: Guardian Name _____

DOES THIS INDIVIDUAL HAVE A DISABILITY? ◯ NO ◯ YES

DIAGNOSIS(ES):

DAY TREATMENT OR WORK SCHEDULE? ◯ NO ◯ YES: Schedule: _____

WHAT ARE THE INTERESTS OF THIS INDIVIDUAL?

PROPOSED GOAL AREAS:

ADDITIONAL INFORMATION/COMMENTS/CONCERNS:

PLEASE SUBMIT THIS FORM TO: **REACH FOR RESOURCES** **ATTENTION: LARISSA BECK, PROGRAM MANAGER OF COMMUNITY LIVING** **5900 GREEN OAK DRIVE, SUITE 303** **MINNETONKA, MN 55343** **FAX: 952-229-4468 • lbeck@reachforresources.org**	**INTERNAL USE ONLY:** **DATE CONTACTED:** **WHO CONTACTED:** **DATE OF INFORMATIONAL MEETING:** **COMPLETED WITH:** **TO BE ASSIGNED TO:**