



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
ATTN: HAILEY HAEN, REFERRAL & INTAKE COORDINATOR
5900 GREEN OAK DRIVE, SUITE 303
MINNETONKA, MN 55343
FAX: 952-229-4468 • hhaen@reachforresources.org
INTERNAL USE ONLY:
DATE CONTACTED:
WHO CONTACTED:
DATE OF INFORMATIONAL MEETING:
COMPLETED WITH:
TO BE ASSIGNED TO: