



COMMUNITY LIVING DEPARTMENT
REFERRAL FORM

PLEASE PRINT

DATE OF REFERRAL: SERVICES(S) REFERRED TO:
(Please indicate Waiver or County Funding)
REFERRED BY: RELATIONSHIP:
AGENCY/ADDRESS:
PHONE: FAX: EMAIL:

PERSONAL INFORMATION

NAME: DOB: PMI:
ADDRESS: CITY/STATE:
ZIP CODE: EMAIL:
PHONE: CELL HOME WORK PHONE CONTACT NAME:
ALTERNATE PHONE: CELL HOME WORK PHONE CONTACT NAME:
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):
GUARDIAN PHONE: GUARDIAN EMAIL:
DOES THIS INDIVIDUAL HAVE A DISABILITY? NO YES

DIAGNOSIS(ES) & CODE:

Empty box for diagnosis and code.

DAY TREATMENT: YES NO WORK SCHEDULE: NO YES (explain):

WHAT ARE THE INTERESTS OF THIS INDIVIDUAL?

Empty box for interests.

PROPOSED GOAL AREAS:

BUDGETING MAIL COOKING OTHER (explain):
PAPERWORK CLEANING MEAL PLANNING

Empty box for other goal areas.

ADDITIONAL INFORMATION/COMMENTS/CONCERNS:

Empty box for additional information.

PLEASE SUBMIT THIS FORM TO:

Reach for Resources

Attn: Hailey Haen

5900 Green Oak Dr., Suite 303, Minnetonka, MN 55343

FAX: 952-229-4468 / hhaen@reachforresources.org