Referral Application

Individual's Information:

Name: _____

DOB: ___/___/____ **Medicaid #: _____**

TABS ID# _____ Diagnosis: _____

Home Address:

_____

Telephone Number: (home) _____ (cell) _____

E-mail address: _____

Address:

_____

_____

School District: _____

Parent/Guardian(s) Information:

Does the individual have a Legal Guardian ☐ Yes ☐ No Date Established: _____

Name: _____

Address:

_____

Telephone Number: (home) _____ (cell) _____

Care Coordinator/Manager Information:

Name: _____

Agency: _____

Address:

_____

Phone Number: _____ E-mail address: _____

Program(s) Interested In:

☐**Community Habilitation**

☐**Hourly Respite**

- ☐ **Afterschool Respite; 2:30p-5:30p**
- ☐ **Respite Camp; 9:00a-2:30p**

Have you received services from Holy Childhood before? ☐ **Yes** ☐ **No**

If yes, which services have you received? _____

Please indicate level of support needed for the following:

Key: Total Support/Assistance/Supervision/Independent

Medication administration _____ **Fire Safety _____**

Community Safety _____ **Eating _____**

Money management _____ **Toileting _____**

Is a Behavior Support Plan or Guidelines in place? ☐ **Yes** ☐ **No**

If yes, please indicate types of behaviors and frequency: _____

_____

_____

Mobility Status:

☐ **Ambulatory**

☐ **Uses manual wheelchair**

☐ **Uses walker**

***Transportation is not offered to/from respite at Holy Childhood. Transportation is the responsibility of the parent/guardian.**

Name of person completing application: _____

Relationship: _____

Date: _____

Please attach the following to this Referral Application:

- **Most recent Individualized Service Plan/Life Plan**
- **Notice of Decision/Proof of Waiver Enrollment**
- **Behavior Support Plan (if applicable)**
- **Psychological Evaluation, prior to age 21**
- **Consent to release information Form**
- **Legal Guardianship papers (if established)**
- **Copy of Medicaid ID Card**
- **DDP2**
- **LCED**