Holy Childhood

Referral Application

Individual's Information:

Name: _____

DOB: ___/___/____ Benefits Received: ☐ SSI ☐ SSD ☐ Other: _____

Medicaid #: _____ Social Security #: _____

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) _____

Medicaid Service Coordinator Information:

Name: _____

Agency: _____

Address:

_____

Phone Number: _____ E-mail address: _____

Program(s) Interested In:

☐Community Habilitation

☐Hourly Respite

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 _____

Community Safety _____

Money management _____

Fire Safety _____

Eating _____

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:

☐ Has own vehicle

☐ Able to use public transportation

☐ Requires vehicle with lift

☐ Needs transportation

Name of person completing application: _____

Relationship: _____

Date: _____

Please attach the following to this Intake Application:

- Most recent Individualized Service Plan
- Behavior Support Plan (if applicable)
- Consent to release information Form
- Legal Guardianship papers (if established)
- Proof of current Waiver enrollment
- LCED
- Current physical
- Current PPD