



REFERRAL FORM



FUNDING SOURCE: ☒ Medicaid Waiver ☐ DARS VENDOR # 1333126 ☐ Local School ☐ Private Pay ☐ Other
☐ Rise vendor #251165

SERVICE: ☐ Benefits Planning NPI #0706401392 ☐ Community Housing Guide NPI #0706401392 ☐ Community Guide NPI #0706401392 ☐ Family Caregiver Training NPI #0950518800
☐ Workplace Assistance NPI#0949377441 ☐ Individual Supported Employment NPI# 949377441

REFERRAL SOURCE

Case Manager: _____ Date of Referral: _____
Email: _____
Telephone: _____ Fax: _____

INDIVIDUAL DATA

Name: _____ SSN #: _____
Address: _____
Client Email: _____ Telephone #: _____
Date of Birth: _____ Isp Dates: _____
Quarterly Dates: _____
Medicaid#: _____

Does the client have a legal guardian? ☐ YES ☒ NO If so, please provide name and address:
Name: _____
Address: _____
Legal Guardian Phone # : _____
Legal Guardian Email: _____

NOTES

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PLEASE ANSWER AND OR FAX THE FOLLOWING INFORMATION:

- | | |
|--|---|
| <input type="checkbox"/> Guardianship order (if applicable) (All).
<input type="checkbox"/> SIS (most recent waiver)
<input type="checkbox"/> Individual married <input type="checkbox"/> Under 22
 Current student
 Received w/in last 12 months unemployment | <input type="checkbox"/> Most recent Risk Assessment (waiver) <input type="checkbox"/>
Behaviour Plan / Protocol, Medical Protocol
<input type="checkbox"/> Received w/in last 12 months worker's
compensation <input type="checkbox"/> DARS Letter (waiver) |
|--|---|

CONSULTING CONNECTION SERVICES | RISE SERVICES

Email: referrals@ccsgroup.org

PHONE (571) 389-3630 | FAX (703) 214-6239