FULL CIRCLE SERVICES, INC

REFERRAL FORM

Name of referred person: ____ SID: ____

Birthday: ____ Diagnosis: ____ Please include most recent psychiatric evaluation and IQ testing.

Current Address of the referred person: ____

Phone Number of referred person: ____

Community of Choice: ____

Does the referred person have a Guardian? ☐Yes ☐No

Name/Address/Phone Number of Guardian: ____

MCO: Please pick one. **MCO #: ____**

REQUESTED SERVICES: check all that apply and fill out hours per month requested

☐Supported Community Living: How many hours being requested per month: ____

☐Home Based Habilitation: Tier Level: ____ Days per month: ____Other: ____

☐Respite (only provided to SCL consumers): Hours per month: ____

☐Day Habilitation: Waiver/HAB/County: ____ Days per week: ____

☐Supported Employment: Waiver/HAB/IVRS: ____ Hours per month: ____

Name and phone number of IVRS worker: ____

☐Consumer Directed Attendant Care: Hours per month: ____

☐Representative Payee (option only for 24 hour sites)

ELIGIBILTY QUESTIONS:

☐Yes ☐ No Is the applicant/guardian willing to participate in program goals and objectives?

☐Yes ☐ No Does the applicant have a documented disability?

☐Yes ☐ No Does the applicant have a funding source willing to fund for requested services?

What is this funding source? ____

☐Yes ☐ No Does the applicant require skilled nursing assistance such as intravenous medications, intravenous feeding tubes, colostomy care, CPAP machine monitoring, and other nursing procedures as determined by FCS INC. If yes, what are they? ____

☐Yes ☐ No Does the applicant have behaviors that are harmful to themselves or others? If yes, what are they? ____

When was the last episode that occurred? ____What was the trigger? ____ Target of violence/self harm? (Staff/family/another person, etc.) ____

What is this individual's monthly income? ____ Is this individual on MEPD? ☐YES ☐NO
(monthly income limit to be eligible for Habilitation is $1507)

INFORMATION REGARDING SERVICES:

What are the present services that this individual is receiving? ____

Will these current services continue if accepted into Full Circle Services, Inc.? ☐ Yes ☐No

What services has this individual had in the past? ____

What are the result expectations of services (outcomes) offered by Full Circle Services, Inc.?

____

Are there any special accommodations needed to make services more successful? ☐ Yes ☐No

If so, what are they? ____

What are the future plans and aspirations of referral person? ____

Name of person making referral: ____

Address: ____

Phone Number: ____

Email: ____

OFFICE USE ONLY

Date referral received_____ FCS staff assigned_____

Date of Initial Intake_____

Devised June 2015
Updated July 2017