**Referral Form**

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| ***Client Information (person referred for service)*** |

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| **Name** (First): | **Name** (Last): | |
| **Address**: | | |
| **City**: | **State**: | **Zip Code**: |
| **Phone**: | **Email**: | |
| **DOB:** | **MA #** | |
| **Is There a Legal Guardian?** YES NO | **Guardian’s Name & Contact Info:** | |
| **Living Situation:** Residential  Lifehsaring  Supported Living  w/ Family  Own  Other: | | |

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| **Nature of Service Requested** (list all that apply):  Risk Screening for Problematic Sexual Behaviors (sexual offender)  Intensive Consult (problematic sexual behaviors or female offender)  Functional Behavior Assessment (FBA)  Ongoing Behavioral Support/Consultation  Sexual Consent Screening |
| **Funding Source** (list all that apply): *Please note all funding sources must be verified.*  ODP Consolidated Waiver (list funding county):  Private Pay  Residential Contract  Community Living Waiver (list funding county):  Base Funds (list funding county): |

***Information on Referral Source (person making the referral)***

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| **Date**: | | |
| **Name** (First): | **Name** (Last): | |
| **Relationship/Entity**: | | |
| **Address**: | | |
| **City**: | **State**: | **Zip Code**: |
| **Phone**: | **Email**: | |
| **County of Residence:** | **SC Name:** | |
| **SC Phone Number:** | **SC Email:** | |

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| **Reason for Referral/Describe Problematic Behaviors or Symptoms**: |