DDA TARGETED CASE MANAGEMENT
REFERRAL INTAKE FORM / WRITTEN AGREEMENT FOR SERVICES

REFERRAL INTAKE FORM

NAME_____ REFERRAL DATE_____

ADDRESS_____ DOB_____

_____ SS#_____

_____ RACE_____

TELEPHONE #_____ SEX_____

SOURCE OF REFERRAL _____

CAREGIVER / REPRESENTATIVE _____ RELATIONSHIP_____

MEDICAL ASSISTANCE #_____ LEGAL GUARDIAN_____

OTHER INSURANCE # _____ PHYSICIAN _____

REFERRAL RECEIVED BY _____ TRANSFER: YES ____ NO _____

The following parties have agreed to accept DDA Targeted Case Management services on behalf of the participant and have been informed of the individual rights and appeals procedure and have received a copy of them:

_____ _____
Date Participant

_____ _____
Date Caregiver / Representative (if applicable)

WRITTEN AGREEMENT FOR SERVICES

PLEASE CIRCLE APPROPRIATE ANSWER: (Y= Yes, N= No)

Y N Participant has a documented developmental disability.
Y N Participant's needs have been discussed and established with the participant, family, Caregiver.
Y N Targeted Case Management and a choice of services have been discussed with the Participant, family or caregiver.
Y N Participant, family or caregiver has chosen Targeted Case Management services, from
_____
(Name of agency providing services)
Y N Individual is 3 years of age or older.
Y N Individual is not receiving similar case management services.

The following party: _____
has agreed to provide DDA Targeted Case Management services on behalf of (The Participant):

FName: _____ LName:_____

_____ _____
Date Resource Coordinator

DISABILITY
Please check all that apply

_____ (1) None
_____ (2) Autism
_____ (3) Behavior Problems
_____ (4) Blindness/Severe Visual Impairment
_____ (5) Cerebral Palsy
_____ (6) Chemical Dependency (including alcoholism)
_____ (7) Cystic Fibrosis
_____ (8) Deafness / Severe Hearing Impairment
_____ (9) Emotional Handicap (including chronic mental illness)
_____ (10) Epilepsy
_____ (11) Head Injury
_____ (12) Mental Retardation
_____ (13) Multiple Scoliosis
_____ (14) Muscular Dystrophy
_____ (15) Orthopedic Impairment
_____ (16) Specific Learning Disability
_____ (17) Speech Language Impairment
_____ (18) Spina Bifida
_____ (19) Spinal Cord Injury
_____ (20) Other Neurological Impairments
_____ (21) Undetermined
_____ (22) Other(s) Please specify _____
_____
_____
_____
_____

CAUSE OF DISABILITY:
_____
_____
_____
_____

SPECIALTY CARE / MEDICAL & REHABILITATION CARE (Previous & Current):
_____
_____
_____
_____