ATTACHMENT 2-B

BEHAVIOR SUPPORT SERVICES REFERRAL FORM

SELECT A REGIONAL OFFICE

☐ Western	1360 Marshall Street, Hagerstown, Maryland 21740
☐ Eastern	926 Snow Hill Road, Building 100 Salisbury, MD 21804
☐ Central	1401 Severn Street, Baltimore, MD 21230
☐ Southern	312 Marshall Avenue, Laurel, MD 20707

Name:Click here to enter text.	
Date of Birth:Click here to enter text.	Sex: ☐Male ☐ Female
With Whom Residing:Click here to enter text.	Phone:Click here to enter text.
Address:Click here to enter text.	
Email address:Click here to enter text.	
M.A.#:Click here to enter text.	
Current DDA Providers:Click here to enter text.	
Coordinator of Community Service:Click here to enter text.	
CCS Email address:Click here to enter text.	
Individual has a legal guardian	Yes ☐ No☐
Name of Legal guardian:Click here to enter text.	Phone:
Legal guardian email address:Click here to enter text.	
Referral Source:Click here to enter text.	Date:Click here to enter text.
Reason for the Referral:Click here to enter text.	
Is the Individual in Waivered Services?	Yes ☐ No☐
Requested Services: ☐Behavior Assessment ☐Behavior Consultation ☐Behavior Support Implementation Services	
This Individual is under 21 years of age and is approved to receive BSS services.	Yes ☐ No☐

Describe prior program efforts to address Challenging BEHAVIORS:

Click here to enter text.