**Adult Services Referral**

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| **REFERRAL SOURCE** | |
| **Referring worker:** |  |
| **Agency:** |  |
| **Address:** |  |
| **Email Address:** |  |
| **Phone #:** |  |
| **Fax #:** |  |
| **Date of Referral:** |  |

**Timeline for services**

**Urgent-person needs services ASAP  Less Urgent-1-6 months  Not urgent-6 months +**

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| **Person being Referred** | | |
| **Name:** |  | |
| **Address:** |  | |
| **Postal Code:** |  | |
| **Phone #:** |  | |
| **Date of Birth:** |  | |
| **Gender:** | Male Female Transgender  Non-Binary | |
| **Support Budget Level (1-7)** | Choose an item. | |
| **Has funding been confirmed** | Choose an item. | |
| **LEGAL STATUS** | | |
| Independent | | SDM PGT Personal Care Property |
| SDM – Other | | Order of Supervision |
| Other please specify: | | |

**CHECK ALL THAT APPLY**

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| **Residential Referral**  **Adult Home Share**  **Shift Staffed Homes**  **Regional Services** | **Supported Living and Housing**  **Supported Independent Living**  **Cluster Housing**  **Regional Services** | **Individualized Community Resources**  **Adult Family Support**  **Adult Day Service**  Choose an item.  **Supported Employment** |

**I am unsure of what service area to select.**

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| Please give a brief description of the person, their needs (include accessibility and personal care needs) and current situation. What services is the person looking for from New Directions? |
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**Thank you for your referral to New Directions Adult Services. You will be contacted by a staff person to gather more information within 2 weeks of receipt of the referral form.**