REFERRAL APPLICATION FORM
For Adult Day Support Services

AccessAbility Incorporated

Agency/Program Referring to: AccessAbility, Inc			
Name:		**DOB:**	**M** ☐ **F** ☐
Residence:		**Residence Type:**	
Address:		**Phone:**	
Residential Contact:	**Phone:**	**Email:**	
Metro Mobility #:			
Guardianship Status:			
Primary Diagnosis:			
Secondary Diagnosis:			
Other Diagnoses:			
Case Manager:	**County:**	**Phone:**	**Email:**
Other Significant Contacts:			
County of Financial Responsibility:			
Does Applicant receive Soc. Security: RSDI ☐ Death Benefits ☐ **Financial Assistance**: MA ☐ SSI ☐ MSA ☐ Other ☐			
Medical Assistance Number:		**Medicare Number:**	
Social Security Number:			
Savings Account: Yes ☐ No ☐			
Burial Account: Yes ☐ No ☐			
Health Insurance: Yes ☐ No ☐			
Life Insurance: Yes ☐ No ☐			
Parent/Guardian/ Significant Other:			
Address:		**Email:**	
Phone (home):	**Phone (cell):**	**Phone (work)**	

Previous Programs/Employment History:

Agency	Dates	Reason for Leaving
	To	
	To	
	To	
	To	

Education Level:	**Graduation:**

Psychologist:	**Phone:**
Address:	
Psychiatrist:	**Phone:**
Address:	
Medical Doctor:	**Phone:**
Address:	
Medications:	
Allergies:	**History of Seizures:** Yes ☐ No ☐
Current Health/Physical Restrictions:	

Special Needs:

Ambulation:	**Toileting:**
Feeding:	**Other:**

Primary Form of Communication: Verbal: ☐ Sign: ☐ Augmentative: ☐

Additional Comments regarding client :
(Programming and behavioral concerns, interests, client strengths, etc.)

The following most recent reports are included with this application:

☐ Physical Examination (w/in 1 year)
☐ Psychological Report
☐ Social History
☐ Screening Document
☐ County Individual Service Plan (w/in 1 year)
☐ Residential Report
☐ School/Vocational Report
☐ Release of Information form

FUNDING SOURCE: ☐ MA ☐ Waivered Services ☐ County ☐ CADI

_____ _____

Signature of Person Completing this Application Date

I verify that, to the best of my knowledge, the person being referred by this Referral Form is not eligible for this particular supported employment service from a vocational rehabilitation program funded under Section 110 of the Rehabilitation Act of 1973 as amended in October of 1986 and delivered by vocational rehabilitation counselors (DRS/VR); nor is the person being referred by this Referral Form eligible for educational services mandated by PL 94-142, MN Rules, part 9525.1560. (State law mandated educational services from birth to age twenty-two.)

_____ _____

Signature of County Case Manager Date

When you have completed this form, please mail or fax it to:

Tonia Hewett, DTH Intake
AccessAbility, Inc.
360 Hoover Street NE
Minneapolis, MN 55413

612-331-2448 Fax

612-331-5958 Phone