



Internal Use Only

Intake Staff:

Date Completed:

# Care Coordination Referral Form

Please enter as much information as possible.

Mail to: Person Centered Services, Intake Dept., 1090A Union Road, Suite 260, W. Seneca, NY 14224

FAX: (716) 671-2175 Email: [Intake@PersonCenteredServices.com](mailto:Intake@PersonCenteredServices.com) Questions? Call (855) 208-3533

Date: \_\_\_\_\_

## Person Seeking Care Coordination

Name:		Male	Female
Address:		Social Security #:	
City, Zip:	County:	Date of Birth:	
Residence Type (ie nursing facility, IRA, family home etc):		TABS ID Number:	
		Medicaid? Yes CIN#:	
Phone Number:	Cell?	Landline?	Email:
Primary Language:	If not English, does the person have translation assistance? Yes No		
If yes: Name:	Phone:	Agency (if applicable):	
School District of Residence:			
Most Recent School Attended:			

## Parent or Guardian Contact Information

Name:	Phone:
Address:	Legal Guardian? Yes No
Email:	Relationship to Individual:

## How did you hear about us?

Referred By:	Relationship to the person seeking Care Coordination (i.e. doctor, teacher, social worker, school psychologist, care manager):
Organization:	
Email:	
Phone:	

For questions: please contact 1-855-208-3533 (Toll Free)

Albanese



**Eligibility: Has the person been diagnosed with a developmental and/or intellectual disability prior to age 22? (Please check all that apply)**

Intellectual Disability Cerebral Palsy Epilepsy/Seizure Disorder Familial Dysautonomia	Autism Spectrum Disorder Other (Mental Health, Developmental Delay, etc):
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**Neurological Impairment: (please specify type of impairment, a list of neurological impairments can be found on [www.ninds.nih.gov/disorders](http://www.ninds.nih.gov/disorders))**

Traumatic Brain Injury	Spina Bifida	Tourette's Syndrome	Prader Willi
Other (please specify)			

**Has the person ever received services and/or eligibility determination from the New York State Office of People with Developmental Disabilities (OPWDD)?**    Yes    No

**If so, when?** \_\_\_\_\_

**Has the person contacted the OPWDD Front Door?**    Yes    No    Unsure

**Name of Front Door Contact:** \_\_\_\_\_

**Has the person attended a front door information session?**    Yes    No

**Please describe the people that support the individual:**

<b>Name:</b>	<b>Relationship:</b>	<b>How does this person support them?</b>
<b>Name:</b>	<b>Relationship:</b>	<b>How does this person support them?</b>
<b>Name:</b>	<b>Relationship:</b>	<b>How does this person support them?</b>

**Has the person experienced any of the following? (check all that apply):**

Mental Hygiene arrests/commitments	Time in Jail	Orders of Protection	Probation
Criminal Charges	Sex offense registry	Parole	Other: