

**REFERRAL APPLICATION FORM  
For Adult Day Training and Habilitation**



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

**Previous Programs/Employment History:**

Agency	Dates	Reason for Leaving
	To	
	To	
	To	
	To	

<b>Education Level:</b>	<b>Graduation:</b>
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<b>Psychologist:</b>	<b>Phone:</b>
<b>Address:</b>	
<b>Psychiatrist:</b>	<b>Phone:</b>
<b>Address:</b>	
<b>Medical Doctor:</b>	<b>Phone:</b>
<b>Address:</b>	
<b>Medications:</b>	
<b>Allergies:</b>	<b>History of Seizures:</b> Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>Current Health/Physical Restrictions:</b>	

**Special Needs:**

<b>Ambulation:</b>	<b>Toileting:</b>
<b>Feeding:</b>	<b>Other:</b>

**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:**

- |   |   |
|---|---|
| <input type="checkbox"/> Physical Examination (w/in 1 year) | <input type="checkbox"/> County Individual Service Plan (w/in 1 year) |
| <input type="checkbox"/> Psychological Report               | <input type="checkbox"/> Residential Report                           |
| <input type="checkbox"/> Social History                     | <input type="checkbox"/> School/Vocational Report                     |
| <input type="checkbox"/> Screening Document                 | <input type="checkbox"/> 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