



Referral for Consumer Services

Office Use Only	
Date rec'd/initials	_____
Date entered/initials	_____

The Arc requires completion of ALL of the following information for individuals requesting consideration for Arc services. The information provided will be kept confidential in accordance with Federal and State Confidentiality Laws and HIPPA Requirements.

Today's date:			
REFERRAL INFORMATION			
<input type="checkbox"/> Mr. <input type="checkbox"/> Miss <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.		Consumer's Legal Name (Last, First, Middle):	
Goes by:		Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
Birth date: / /		Age: SSN: Gender: <input type="checkbox"/> M <input type="checkbox"/> F	
Street address:		Email Address: Home telephone #: () -	
City: State:		ZIP Code: Cell telephone #: () -	
Primary Diagnosis:			
Referred by:		Relationship: <input type="checkbox"/> Case Manager <input type="checkbox"/> Arc Consumer <input type="checkbox"/> Family <input type="checkbox"/> Arc Employee <input type="checkbox"/> Friend <input type="checkbox"/> Physician <input type="checkbox"/> Teacher <input type="checkbox"/> Other: _____	
Telephone no () -			
Services are requested for: <input type="checkbox"/> Adult <input type="checkbox"/> Child		Funding Source: <input type="checkbox"/> HCBS/MR Waiver* <input type="checkbox"/> HCBS/I&H Waiver* <input type="checkbox"/> HCBS/BI Waiver* <input type="checkbox"/> UW Funding <input type="checkbox"/> DHS Funding <input type="checkbox"/> Other: _____	
		Type of Service** : <i>In-Home</i> <i>Site-Based</i> (check all that apply) <input type="checkbox"/> Respite 1:1 <input type="checkbox"/> SDP <input type="checkbox"/> Respite - Group <input type="checkbox"/> BASICS <input type="checkbox"/> SCL <input type="checkbox"/> OASIS <input type="checkbox"/> IMMT <input type="checkbox"/> CHOICES <input type="checkbox"/> CDAC	
Reason for referral:		Title 19# (if applicable):	

* All HCBS Waiver Referrals must be accompanied by a copy of the Medicaid Card and the Functional Assessment to be processed.

** If you are unsure of these services, you can obtain a description online at www.arceci.org or you may leave this question blank.

GUARDIAN INFORMATION			
Legal Guardian(s) Name:		Relationship(s):	
Street address (if different from Consumer's):		Email Address: Home phone no. (if differs from Consumer's): () -	
City: State:		ZIP Code: Cellular phone no.: () -	
Employer:		Work Hours: Work phone no.: () -	
Primary Caregiver Name (if different from guardian):		Relationship: Contact telephone no: () -	

Referrals are processed within 5 business days of receipt. To access services, an intake must be conducted with the individual. Please list the day(s) and time(s) that work best for the individual, his/her guardian/caregiver and any other parties who will be present at the intake.

Intake Day Preference:	Intake Time Preference:
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I hereby acknowledge that all information in this document is accurate to the best of my knowledge. I understand that I am required to notify The Arc in writing of any changes to this document.

Signature (If this document is emailed, please type name here) _____ Date _____

Completed forms must be signed, dated and returned to The Arc:

By Mail:
680 2nd Street SE, Suite 200
Cedar Rapids, IA 52401

By Fax:
319-365-9938

Program Manager Only	
Reviewed (initials/date):	_____
Results:	<input type="checkbox"/> Intake Assigned to FSC <input type="checkbox"/> Referred to Non-Arc Services <input type="checkbox"/> Other: _____