

UKIAH VALLEY ASSOCIATION FOR HABILITATION REFERRAL INFORMATION

Please check all that apply:

- Mayacama Industries—Bridge Services
- Mayacama Employment Service
- Mayacama Employment Service – Forensic Component
- Rural Adult Program / BMAC
- Rural Adult Program /Enhanced Services
- Rural Adult Program / Mobile Day Services
- L.I.F.E. Services
- L.I.F.E. Services– Forensic Component

To be completed by the referral agent prior to screening.

APPLICANT’S NAME: _____ PHONE: _____

ADDRESS: _____ BIRTH DATE: _____

EDUCATION: _____

REFERRAL AGENCY: _____

REASON FOR REFERRAL:

OUTCOMES EXPECTED:

HOW LONG HAS YOUR AGENCY BEEN WORKING WITH THE APPLICANT?

HOW FREQUENT HAVE YOUR CONTACTS WITH THE APPLICANT BEEN IN THE LAST SIX MONTHS?

WHAT SERVICES HAS YOUR AGENCY PROVIDED?

REFERRAL INFORMATION (continued)

WHAT OTHER AGENCIES ARE INVOLVED WITH THE APPLICANT?

WHAT IS THE APPLICANT'S CURRENT LIVING SITUATION?

IS THIS A STABLE SITUATION OR LIKELY TO CHANGE IN THE NEAR FUTURE?

WHAT IS THE APPLICANT'S FAMILY, CULTURAL AND SOCIAL SITUATION? PLEASE COMMENT ON ANY KNOWN STRENGTHS OR PROBLEM AREAS--IF THEY ARE LIKELY TO AID OR HINDER APPLICANT'S PERFORMANCE IN A WORK SITUATION OR RECEIVING OTHER SERVICES.

LIST ANY CONVICTIONS. FELONY: _____ DATE: _____

MISDEMEANOR: _____ DATE: _____

LIST ANY MEDICAL CONSIDERATIONS, ALLERGIES, MEDICATIONS:

WHAT IS THE APPLICANT'S PRIMARY DISABILITY? _____

SECONDARY DISABILITY: _____

REFERRAL INFORMATION (continued)

WHAT IS THE APPLICANT'S COMMUNICATION ABILITY?

ARE THERE ANY BEHAVIORAL CONCERNS WITH THIS INDIVIDUAL, SUCH AS INAPPROPRIATE SOCIAL OR SEXUAL BEHAVIOR, AGGRESSIVENESS, DEPRESSION ETC.?

IS THE APPLICANT UNDER GUARDIANSHIP OR CONSERVATORSHIP? _____

IF SO, PLEASE COMPLETE THE FOLLOWING.

GUARDIAN/CONSERVATOR NAME: _____

PHONE _____ ADDRESS: _____

RELATIONSHIP: _____

NOTE IF THE FOLLOWING ITEMS ARE:

	ATTACHED	NOT AVAILABLE	NOT APPLICABLE
PSYCHOLOGICAL EVALUATION	_____	_____	_____
PSYCHIATRIC REPORT	_____	_____	_____
GENERAL MEDICAL EXAM REPORT	_____	_____	_____
SPECIALISTS REPORTS (Medical, speech, P.T., O.T. etc.)	_____	_____	_____
VOCATIONAL INFORMATION	_____	_____	_____
IPP, IWRP OR IEP	_____	_____	_____
CDER	_____	_____	_____
RELEASE OF INFORMATION	_____	_____	_____

REFERRAL AGENT'S SIGNATURE

DATE: _____

Send completed form to: U.V.A.H.
P.O. Box 689 FAX (707) 468-9149
Ukiah, CA 95482