REFERRAL FORM

Albany ARC Advocacy Resource Center
Supporting People With Disabilities
P.O. Box 71026, Albany, GA 31708-1026
3005 Old Dawson Road, Albany, GA

Date: _____

Name of Individual to be Served: _____

Phone #s: _____

Address: _____

Person/Agency Making Referral: _____ **Relationship:** _____

Phone #s: _____

INDIVIDUAL'S INFORMATION:

Date of Birth: _____ **Medicaid #:** _____

Social Security #: _____ **Medicare #:** _____

Medicaid Waiver? ☐ **YES** ☐ **NO** **If "NO," applying for a waiver?** ☐ **YES** ☐ **NO**

Diagnosis (list all known) _____

Axis 1 _____ **Axis 2** _____ **Axis 3** _____

Assessments/Evaluations? ☐ **YES** ☐ **NO (if YES, attach copies)**

Income Source(s): _____

Reason for Referral: _____

_____

Family Aware of Referral? ☐ **YES** ☐ **NO**

Contact: _____ **Relationship:** _____

Phone #s: _____ **Email, if available:** _____

Other Pertinent Information: _____

_____

Intake Person:

_____ _____ _____

Signature **Title/Program** **Date**

For more information, call (229) 888-6852, ext. 209.

Revised 10/12/17 MMc