

**UKIAH VALLEY ASSOCIATION FOR HABILITATION
REFERRAL INFORMATION**

Please check all that apply:

- | | |
|------------------------------------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Mayacama Industries—Bridge Services | <input type="checkbox"/> Rural Adult Program I |
| <input type="checkbox"/> Mayacama Industries—Supported Employment Crew | <input type="checkbox"/> Rural Adult Program IV |
| <input type="checkbox"/> Mayacama Employment Service | <input type="checkbox"/> Enhanced Services |
| <input type="checkbox"/> L.I.F.E. Services | <input type="checkbox"/> Mobile Day Services |

To be completed by the referral agent prior to screening.

APPLICANT'S NAME: _____ PHONE: _____

ADDRESS: _____ BIRTH DATE: _____ EDUCATION _____

AGENTS NAME: _____ 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?

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?

REFERRAL INFORMATION (continued)

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.

Please list any convictions. Felony: _____ Date: _____ Misdemeanor: _____ Date: _____

Please list any medical considerations, allergies, medications.

What is the applicant's primary disability?

Secondary disability? _____

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.

NAME: _____ PHONE: _____

ADDRESS: _____ RELATIONSHIP: _____

PLEASE RESPOND WITH THE FOLLOWING:

	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 OR IEP	_____	_____	_____
CDER	_____	_____	_____
RELEASE OF INFORMATION	_____	_____	_____

ADDITIONAL COMMENTS _____

AGENT'S SIGNATURE _____ DATE _____

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

Revised 11/09