**INDEPENDENT LIVING SERVICES**

**REFERRAL FORM**

|  |  |  |  |
| --- | --- | --- | --- |
| **Consumer Information:** | | | |
| Name: |  | Date of Birth: |  |
| Address: |  | Phone: |  |
|  |  | Disability: |  |
| Email: |  |  |  |

|  |  |  |
| --- | --- | --- |
| Other  Services  Receiving: | Vocational Rehabilitation (VR)  Adult Basic Education (ABE)  County Case Management  Psychological/Psychiatrist Services | |
| Other: |  |

**Release of Information:**

|  |  |  |  |
| --- | --- | --- | --- |
| I, |  | hereby authorize |  |

(consumer’s name) (referral source)

to release the information on this form to SWCIL. I have been advised that this information will be kept confidential and will be used only to aid SWCIL in assisting me to pursue independent living services and, if appropriate, in the development of my service plan.

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Signature of Consumer |  | Date |

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Signature of Parent/Guardian (if necessary) |  | Date |

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Signature of Witness (if necessary) |  | Date |

|  |  |  |  |
| --- | --- | --- | --- |
| **Referral Source:** | | | |
| Agency/School: |  | | |
| Contact Person & Title: |  | | |
| Address: |  | Phone: |  |
| Email: |  |  |  |
| Referral Signature: |  | Date: |  |

**On the back please provide information about the individual to assist SWCIL staff in delivering services (i.e. – areas of need, information about the disability and living situation, employment status, best time to contact, etc.). Please be as specific as possible.**

Fax, mail or e-mail completed form to SWCIL using the contact information listed above.

*This form is available in alternate formats upon request.*

|  |  |
| --- | --- |
| Name of Consumer: |  |

|  |
| --- |
|  |

SWCIL Independent Living Services Referral Form

Page 2