Reach For Your Potential, Inc.

1705 S. 1st Ave., Suite I, Iowa City, Iowa 52240
PH: 319-354-2983 FAX: 319-354-3221

Referral Information Form

Today's Date:

Personal Information

Name of referral (First, Middle, Last):

Birthday:

State ID #:

Social Security:

Current Living Situation

Address:

Telephone:

Does individual currently receive services/live with another agency?

If yes - Type of services (SCL - hourly/24 hour, Respite, CDAC, etc.):

Name of Agency:

Address:

Telephone:

Legal Status

Name of guardian(s):

Relationship to individual:

Address:

Telephone:

If own guardian - Name of parent(s)/contact person:
Relationship to individual:

Address:

Telephone:

<u>Medical and Skills Level</u>
(Describe the following areas in terms of abilities or needs)

Current diagnosis and IQ:

Medical issues/concerns/supports required:

Medical equipment/supplies used:

Ambulatory/transfers required:

Medications (type and dosage or attach list):

Self-Cares:

Continence:

Behaviors:

Emotional/social functioning:

Supervision:

Other:

Vocational

Is individual employed?

Hours of work per week:

Job title/description:

Employer:

Address:

Telephone:

Does individual receive vocational services through another agency?

If yes - Agency:

Address:

Telephone:

Sources of Income

Earnings from employment (Y or N, amount):

SSI (Y or N, amount):

SSDI (Y or N, amount):

Food stamps (Y or N, amount):

Housing assistance (Y or N, amount):

1705 S. 1st Ave., Suite I, Iowa City, Iowa 52240
PH: 319-354-2983 FAX: 319-354-3221

Private Health Insurance (Y or N):

Private Dental Insurance (Y or N):

Title XIX # (if applicable):

Medicare # (if applicable):

Funding source for services:

Other:

Services Individual Would Like to Apply For

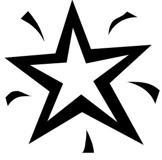
Supported Community Living (Y or N):
- 24-Hour Residential Home (Y or N):
- Hourly Home/Apartment (Y or N):
- Hourly Drop-In Services (Y or N):

Adult Day Center (Y or N):
- Full Days (Y or N):
- Half Days (Y or N):
- Number of Days per Week:
- Preferred Schedule for Attendance:

Desired Start Date:

What would you see as program goals for the individual?

Reason(s) for wanting services with Reach For Your Potential (RFYP). Reason(s) if discharging from services with another agency.



Reach For Your Potential, Inc.

1705 S. 1st Ave., Suite I, Iowa City, Iowa 52240
PH: 319-354-2983 FAX: 319-354-3221

Referral Source

Name of person making referral / completing this form:

Relationship to applicant:

Agency:

Address:

Telephone:

Fax:

Will your agency continue to provide services to the individual during his/her participation with RFYP?

The following items are needed for admission screening and appropriate program placement:

Social History
Assessment
Current physical and dental exams
Cognitive/Psychological Evaluations
Individual Service Plan
Signed release of information form between your agency and RFYP
Additional information that would be helpful to RFYP

Please send these items along with the referral form to:

Diana Jones
Reach For Your Potential
1705 S. 1st Avenue, Suite I
Iowa City, Iowa 52240
Telephone: (319) 354-2983
Fax: (319) 354-3221
Email: djones@reachforyourpotential.org

Consumer Name: *Date of Birth:* *State ID#:*