LIBERTY HOUSE FOUNDATION, INC.

54 BAY STREET, GLENS FALLS, NY 12801

REFERRAL FORM

1. IDENTIFYING DATA:

Name: ____________________ Date of Referral: ____________________

Address: ____________________ Phone #: ____________________

County: ____________________ SS #: ____________________

D.O.B.: ____________________ Medicaid #: ____________________

2. SERVICES REQUESTED:

1. Pre-Vocational Services: ____________________ 3. Benefits Management: ____________________.

2. Employment Services: ____________________ 4. Rep Payee: ____________________.

3. DIAGNOSIS:

DIAGNOSIS		DSM-5	
AXIS I:			
AXIS II:			

4. BRIEF HISTORY OF ILLNESS: ____________________

____

____

5. HOSPITALIZATIONS:

NAME OF FACILITY	DATE OF ADMISSION	DATE OF DISCHARGE

6. CURRENT MEDICATIONS:

NAME	DOSAGE	SCHEDULE

7. MEDICAL INFORMATION:

Physician: ____________________ Phone #: ____________________

Psychiatrist: ____________________ Phone #: ____________________

Therapist: ____________________ Phone #: ____________________

8. FINANCIAL INFORMATION:

Source of Income	Amount	Source of Income	Amount
PA	________	PENSION/RETIREMENT	________
SSI	________	FOOD STAMPS	________
SSD	________		

9. CRIMINAL HISTORY:

Have you ever been **convicted** of a **misdemeanor** in any jurisdiction? ____________________

If yes, for what? ____________________

Have you ever been **convicted** of a **felony** in any jurisdiction? ____________________

If yes, for what? ____________________

Do you have any pending criminal charges in any jurisdiction? ____________________

If yes, for what? ____________________

Are you currently on **probation**? ____________________ If yes, for how long? ____________________

If yes, for what? ____________________

Are you currently on **parole**? ____________________ If yes, for how long? ____________________

If yes, for what? ____________________

10. FAMILY INFORMATION:

Spouse ____________________ # of children ____________________

Parents ____________________ Phone # ____________________

Current family contacts ____________________

In case of an emergency, notify: ____________________

11. HOUSING INFORMATION:

Present: ____________________ Projected: ____________________

12. EDUCATIONAL/VOCATIONAL INFORMATION: List name of school/program or employment:

____

13. DOES THE APPLICANT HAVE AN OPEN ACCES-VR CASE? **YES** **NO**

Name of Counselor: ____________________

14. ARE YOU CURRENTLY RECEIVING SERVICES FROM ANY OTHER AGENCY? **YES** **NO**

If so, who? ____________________

15. IS THE APPLICANT CURRENTLY RECEIVING SERVICES THROUGH OPWDD? **YES** **NO**

Medicaid Service Coordinator: ____________________

Enrolled in waiver? **YES** **NO**

16. SIGNATURE OF REFERRING AGENT: ____________________

TITLE: ____________________ **AGENCY:** ____________________ **DATE:** ____________________