Durham County Community Living Programs, Inc.

Post Office Box 51159
Durham, North Carolina 27717-1159

Consumer Referral Form

Consumer Name:____________________________ Date:________________________________

Current Address:____

Phone #:___________________________________ D.O.B.______________ Record #: _______

Medicaid #:________________________________ S.S.#:________________________________

Other Insurance: ____

Guardian: Name:____

Address:____

Phone #: (H)______________________ (W)_______________________________

Requested Program Name:____

Reason for Requesting Admission:____

____

Service Being Requested:

_____Group Living
Will Consumer need 24 hour awake staff?______________________________
Can Consumer be left unsupervised?___________________________________
Length of time Consumer can be left unsupervised?_____________________

_____Personal Assistance
Hours/schedule requested: ____

_____Innovations (formerly CAP-MR/DD)
Service requested: ____
Hours/schedule requested: ____

_____ Supported Condos/Apartment Living
Total Gross Annual Income (Earned and Unearned) _________________________

List each person who would live with Consumer if Consumer receives housing assistance (incl consumer)

Last Name	First Name	Age	Sex	Relationship to Head of Household	Annual Income	SS#

Does anyone live with Consumer now who is not listed above? ______Yes ______No
If Yes, please provide an explanation:____

____

Is there any expectation of change in the Consumer's household composition? ____Yes ____No
If Yes, please provide an explanation:____

____

Are There any Special Housing Needs for the Consumer?________________________________

____

Mark one item in "a" and "b" (For statistical purposes only)

a. Is the Consumer:
   - _____American Indian or Alaskan Native
   - _____African American
   - _____Native Hawaiian or Other Pacific Islander
   - _____Asian
   - _____Causasian

b. Ethnicity of Consumer:
   - _____Hispanic or Latino
   - _____Non-hispanic or Latino

Innovations or Residential Eligible Diagnosis (DSM IV Code and Description):_________

____

Other Diagnoses:____

____

Describe medical needs of consumer: ____

____

Describe behaviors that are destructive, violent, or aggressive:__________________________

____

____

Is the Consumer currently involved in the use of illegal drugs?_____________________________

Is the Consumer registered in a State Sex Offender Lifetime Registration?__________________

Place of Employment/Day Program:____

____

Other Services Consumer Receives:____

____

Describe Consumer's Abilities in the Following Areas:

1. Feeding:____
2. Bathing:____
3. Dressing:____
4. Controlling urine and bowels:___________________________________
5. Speech, Hearing, and Sight:____________________________________
6. Ambulation:____
7. Assistive Devices: ____

Consumer Preferences: ____

Consumer Goals:____

Expected Outcome:____

Contact Person:____

Name and Title of Person Submitting Form:__________________________________

Applicant Certification: I certify that the statements made on this preliminary referral are true and complete to the best of my knowledge and belief. I understand that providing false statements or incomplete information when applying for housing assistance may result in punishment under Federal Law.

Signature of Consumer | Date

Signature of Guardian (if applicable) | Date