FRM-HS-00220: **Referral Form (Iowa Human Services & Transportation only)**
Revision Date(s): 01/22/2018 MH, 1/2021 ss

Date ______________________

Referring Individual ______________________ Referring Agency ______________________

Telephone Number ______________________ Email ______________________

PROGRAM REFERRING TO (*check all that apply*)

- ☐ Hourly Supported Community Living
- ☐ 24 Hour Supported Community Living
- ☐ Employment Services
- ☐ Accessible Housing
- ☐ Day Program (Adult)
- ☐ Day Program "Connect Club" (16-21 years of age)
- ☐ Transportation
- ☐ Home Health Care

CURRENT RESIDENTIAL STATUS

☐ Independent ☐ Family ☐ Other ______________________

PERSONAL INFORMATION

Name ______________________ DOB ______________________

Street Address ______________________

City ______________________ State __________ Zip ______________________

Home Phone ______________________ Cell Phone ______________________

Email ______________________

Medicaid State ID ______________________ MCO ID ______________________

DIAGNOSIS/BARRIERS

Primary Diagnosis ______________________

Other Diagnosis
(include medical/psychiatric/etc.) ______________________

Identified Barriers ______________________

Current Services ______________________

FUNDING SOURCE

☐ Private Pay ☐ Managed Care ☐ Other ______________________

Managed Care Organization (MCO) ______________________

Case Manager/Agency ______________________

Case Manager Phone ______________________ Email ______________________

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RESIDENTIAL CONTACT INFORMATION (*if applicable*)

Agency Name ____________________

Contact Person ____________________ Telephone Number ____________________

GUARDIAN INFORMATION *(if applicable)*

Name ____________________ DOB ____________

Street Address ____________________

City ____________________ State ________ Zip ____________

Home Phone ________ Cell Phone ____________________

Email ____________________ ____

Medicaid State ID ____________________ MCO ID ____________

TRANSPORTATION DETAILS (*if applicable*)

Type of Transport ☐ Medical ☐ Non-Medical

Pick Up Address ____________________

Drop Off Address ____________________

Appointment Time ____________________

Return Trip Time ____________________

Reason for Trip ____________________

Frequency ____________________

Start Date ____________________

FOR INTERNAL USE ONLY

This referral/intake was received by ____________________ Date ____________

Internal Tracking System updated by ____________________ Date ____________

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