Coshocton County Board of DD
Intake/Referral Form

Date of Referral: _____

Name: _____ Date of Birth: _____ Age: _____

Address: _____ Phone: _____

Parents/Caregiver: _____ _____
(Father) (Mother)

Address: _____ Phone: _____

Father Work Phone: _____ Mother Work Phone: _____

Legal Guardian: _____ Date of Guardianship: _____

School District: _____

Social Security #: _____ Medicaid #: _____ Medicare #: _____

Type(s) of Services Requested **(Please check all that apply)**:

☐ Help Me Grow (Complete *Part 1)* ☐ Leisure/Recreation ☐ O.T.

☐ Early Intervention (Complete *Part 2)* ☐ Adult Services ☐ P.T.

☐ Eligibility Determination ❍ Community Employment ☐ Speech

☐ Case Management/Service Coordination ❍ Habilitation ☐ Other _____

☐ Supported Living/Waiver Services/Housing ❍ Work Services ☐ Residential Placement (ICF/MR)

☐ Family Resources

Referral Taken By: _____

Person/Agency Who Referred: _____ Contact Person: _____

Address: _____ Phone: _____

Reason for Referral: _____

_____

***Part 1***

If referral is for pregnancy, mother's due date: _____ Mother's Date of Birth: _____

Names and ages of siblings: _____

Date-Initial Contact/TOTS: _____ HMG: _____ Date – Initial Home Visits/TOTS: _____ HMG: _____

***Part 2***

Date-Initial Contact/TOTS: _____ E.I.: _____ Date – Initial Home Visits/TOTS: _____ E.I.: _____

Comments (i.e., directions to home, etc.): _____

_____

_____ _____
Signature of Person Completing Form Date

Referral given to: _____ By: _____ Date: _____
Referral given to: _____ By: _____ Date: _____
Referral given to: _____ By: _____ Date: _____
Referral given to: _____ By: _____ Date: _____
Referral given to: _____ By: _____ Date: _____

Route: Forward Original to Enrollee File and Copy to Appropriate Staff