

Coshocton County Board of MRDD  
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 #: \_\_\_\_\_

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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

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Referral Taken By: \_\_\_\_\_

Person/Agency Who Referred: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Reason for Referral: \_\_\_\_\_

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**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.: \_\_\_\_\_

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

\_\_\_\_\_

Signature of Person Completing Form

Date

Referral given to: \_\_\_\_\_ By: \_\_\_\_\_ Date: \_\_\_\_\_

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