



## Referral for Adult Day & Employment Services

Referral Date: \_\_\_\_\_

### Services Requested

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Day Support Options             | <input type="checkbox"/> Individualized Day – Non-vocational | <input type="checkbox"/> Senior Supports   |
| <input type="checkbox"/> Group Supported Employment      | <input type="checkbox"/> Individualized Day - Vocational     | <input type="checkbox"/> Personal Supports |
| <input type="checkbox"/> Individual Supported Employment |  |  |

### **Individual Information**

Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_

Guardian/Conservator: \_\_\_\_\_  
Phone: \_\_\_\_\_

### **Referral Information**

Referral Source:    DDS        Parent        School        Other: \_\_\_\_\_  
Contact Name: \_\_\_\_\_  
Telephone & Extension: \_\_\_\_\_

Funding Source: \_\_\_\_\_

### Diagnosis

Primary: \_\_\_\_\_  
Secondary: \_\_\_\_\_

### Language

Primary: _____	<input type="checkbox"/> Speak	<input type="checkbox"/> Read	<input type="checkbox"/> Write	<input type="checkbox"/> Non-verbal
Secondary: _____	<input type="checkbox"/> Speak	<input type="checkbox"/> Read	<input type="checkbox"/> Write	<input type="checkbox"/> Non-verbal

### Educational Background

<input type="checkbox"/> Special Education Certificate/Diploma	School: _____
<input type="checkbox"/> High School Diploma/GED	School: _____

Reading Level: \_\_\_\_\_

**Work History**

Job Title & Employer: \_\_\_\_\_

Job Title & Employer: \_\_\_\_\_

**Additional Information**

Transportation Needed:      Yes    No

Other Services currently receiving: \_\_\_\_\_

Individual's Expectations: \_\_\_\_\_

**Referral Source, please provide the following:** Release of Information forms, current Individual Plan/School IEP, Level of Need, Behavior Plan/Therapeutic Guidelines, Psychological and any other appropriate supporting documents (i.e. PT, OT, Speech, Dietary, etc.).

Please forward this referral form to the *attention of the Director of Adult Program Services* at: [kbuck@escrec.org](mailto:kbuck@escrec.org)

or

Mail to:  
*Easterseals Capital Region & Eastern Connecticut*  
24 Stott Avenue  
Norwich, CT 06360

**FOR EASTERSEALS ONLY**

Follow Up Action: \_\_\_\_\_

Date: \_\_\_\_\_

Accepted:    Yes    No, Reason: \_\_\_\_\_

Intake Date: \_\_\_\_\_