

DAKOTA COUNTY  
DEVELOPMENTAL DISABILITIES SECTION  
COMMON REFERRAL APPLICATION – ADULT DAY TRAINING AND HABILITATION /  
**SUPPORTED EMPLOYMENT, ETC.**

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

**Applying to:**

- |                                       |                                     |                                   |                                       |   |
|---------------------------------------|-------------------------------------|-----------------------------------|---------------------------------------|---|
| <input type="checkbox"/> Lifeworks    | <input type="checkbox"/> MRCI       | <input type="checkbox"/> ProAct   | <input type="checkbox"/> Chrestomathy | <input type="checkbox"/> Midwest Special Services |
| <input type="checkbox"/> Apple Valley | <input type="checkbox"/> Burnsville | <input type="checkbox"/> Eagan    |                                       | <input type="checkbox"/> Burnsville               |
| <input type="checkbox"/> Burnsville   | <input type="checkbox"/> Lakeville  | <input type="checkbox"/> Red Wing |                                       | <input type="checkbox"/> Eagan                    |
| <input type="checkbox"/> Hastings     |                                     |                                   |                                       |   |
| <input type="checkbox"/> Mendota Hgts |                                     |                                   |                                       |   |
| <input type="checkbox"/> St. Paul     |                                     |                                   |                                       |   |

Other: \_\_\_\_\_ Location: \_\_\_\_\_

Client Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_  M  F

Social Worker: \_\_\_\_\_ Phone: \_\_\_\_\_

County of Financial Responsibility: \_\_\_\_\_

Residence Name:	Residence Type:
Address:	
Residential Contact:	Phone:
Guardianship Status: <input type="checkbox"/> Own Legal Representative <input type="checkbox"/> Private Guardianship <input type="checkbox"/> State Guardianship	
Name of Guardian:	Phone:
Level of Functioning <input type="checkbox"/> No mental retardation <input type="checkbox"/> Mild (IQ – 50 to 69) <input type="checkbox"/> Moderate (IQ – 35 to 49) <input type="checkbox"/> Severe (IQ – 20 to 34) <input type="checkbox"/> Profound (IQ < 20)	
Primary Diagnosis:	
Secondary Diagnosis:	
Other Diagnoses:	

Social Security Benefits:	<input type="checkbox"/> SSI	<input type="checkbox"/> RSDI
Financial Assistance?	<input type="checkbox"/> MA	<input type="checkbox"/> MA-EPD <input type="checkbox"/> MSA <input type="checkbox"/> Other
Medical Assistance Number:	Medicare Number:	
Social Security Number:		
Health Insurance Info:	Policy #:	

Primary Contact:	Relationship:
Address:	
Phone (Home): ( )	Phone (Work) ( )

Secondary Contact:	Relationship:
Phone (Home): ( )	Phone (Work): ( )

Other Significant Contact:	Phone:
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**PREVIOUS PROGRAMS / EMPLOYMENT HISTORY:**

Agency	Dates	Reason for Leaving
	To	
	To	

Education / Level:	Graduation:
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Medical Doctor:	Phone: ( )
Address:	

Psychiatrist:	Phone: ( )
Address:	

Psychologist	Phone: ( )
Address:	

Medication(s)	Dosage / Time	Reason

Allergies:	History of Seizures: <input type="checkbox"/> Yes <input type="checkbox"/> No
	Type:

CURRENT HEALTH / PHYSICAL RESTRICTIONS:

<u>STAFFING RATIO / SUPERVISION NEEDED</u>

**DAY SERVICES REQUESTED**

<b>VOCATIONAL</b> <i>RS, School, Private, Insurance</i>	<b>EMPLOYMENT</b> <i>County, CADI, Private, other</i>	<b>DT&amp;H / DAY SERVICES</b> <i>County, MA/ICF, MR/RC, School</i>	<b>TRAUMATIC BRAIN INJ.</b> <i>TBI, CADI, Private/Insurance</i>
<input type="checkbox"/> Assessment/Center <input type="checkbox"/> Assessment/Enclave <input type="checkbox"/> Assessment/Individual <input type="checkbox"/> Work Adjustment Center <input type="checkbox"/> Work Adjustment Comm <input type="checkbox"/> Job Placement <input type="checkbox"/> Job Coaching <input checked="" type="checkbox"/> Transition Adjustment <input type="checkbox"/> Extended School(summer) <input type="checkbox"/> Transportation  Days/schedule per week: M Tu W Th F  <input type="checkbox"/> Full Day <input type="checkbox"/> Partial Day <input type="checkbox"/> Other: _____  Comments:	<input type="checkbox"/> Extended Employment <input type="checkbox"/> Enclave/Supported <input type="checkbox"/> Ind. Site/Supported Emp <input type="checkbox"/> Transportation  Days/schedule per week: M Tu W Th F  <input type="checkbox"/> Full Day <input type="checkbox"/> Partial Day <input type="checkbox"/> Other: _____  Comments:	<input type="checkbox"/> Extended Employment <input type="checkbox"/> Enclave <input type="checkbox"/> Ind. Site/Supported Emp <input type="checkbox"/> Supported Empl. Hrly. <input type="checkbox"/> School Transition <input type="checkbox"/> Life Skills <input type="checkbox"/> Personal Support <input type="checkbox"/> Transportation  Days/schedule per week: M Tu W Th F  <input type="checkbox"/> Full Day <input type="checkbox"/> Partial Day <input type="checkbox"/> Other: _____  Comments:	<input type="checkbox"/> Center/Pre-Vocational <input type="checkbox"/> Adult Day Care <input type="checkbox"/> Enclave/Supported <input type="checkbox"/> Supported Employment/Independent <input type="checkbox"/> Transportation  Days/schedule per week: M Tu W Th F  <input type="checkbox"/> Full Day <input type="checkbox"/> Partial Day <input type="checkbox"/> Other: _____  Comments:

<b>FUNDING SOURCE:</b> <input type="checkbox"/> MA (ICF) <input type="checkbox"/> Waivered Services <input type="checkbox"/> County <input type="checkbox"/> MR/RC <input type="checkbox"/> CADI <input type="checkbox"/> TBI <input type="checkbox"/> School <input type="checkbox"/> Rehabilitation Services <input type="checkbox"/> Private
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**Duplication of Service Notification**

I verify that, to the best of my knowledge, the person being referred by this Referral Agent is not eligible for this particular supported employment service from a vocational rehabilitation program funded under Section 110 of the Rehabilitation Act of 1973 as amended in October of 1986 and delivered by vocational rehabilitation counselors (DRS/VR); nor is the person being referred by this Referral Application eligible for educational services mandated by PL 94-142, MN Rules, Part 9525.1560. (State law mandated educational services from birth to age 21.)

Signature of County Case Manager \_\_\_\_\_

Date \_\_\_\_\_

**THE FOLLOWING MOST RECENT REPORTS ARE INCLUDED WITH THIS REFERRAL APPLICATION:**

- |   |   |
|---|---|
| <input type="checkbox"/> Physical Examination (within 1 year) | <input type="checkbox"/> County Individual Service Plan (within 1 year) |
| <input type="checkbox"/> Psychological Report                 | <input type="checkbox"/> Residential Report                             |
| <input type="checkbox"/> Social History                       | <input type="checkbox"/> School / Vocational Report                     |
| <input type="checkbox"/> Screening Document                   | <input type="checkbox"/> Authorization to Release Information           |



**PROACT**

3195 Neil Armstrong Blvd. Eagan, MN 55121  
Intake Specialist (651) 289-3151 fax: (651)686-0312

To: Referral Source  
Re: new consumer referrals

**CRIMINAL BACKGROUND INFORMATION**

**Please complete the following:**

**TODAYS DATE:** \_\_\_\_\_

**CONSUMER NAME:** \_\_\_\_\_

**DOES NOT HAVE A CRIMINAL BACKGROUND**

**HAS A CRIMINAL BACKGROUND, SEE BELOW\***

**\*COMMENTS:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Referral Source Signature:** \_\_\_\_\_

**PROACT, INC.**  
**RELEASE OF PRIVATE INFORMATION**

I, _____ (name of participant)	authorize _____ (agency, person making disclosure)
to tell/show: _____ (agency/person receiving the disclosure)	
in: <input type="checkbox"/> written <input type="checkbox"/> audio <input type="checkbox"/> pictorial <input type="checkbox"/> photographic <input type="checkbox"/> verbal <input type="checkbox"/> electronic <input type="checkbox"/> media form (check all that apply)	
the following information: (specific information requested)	
for the specific purpose and use of:	

I understand that my records are protected under the Minnesota Government Data Practices Act and cannot be disclosed (used) without my written signature. I also understand that I can change my mind at any time unless this has already been used (ie: brochures, video, etc.) and that this agreement ends in one year.

Date signed \_\_\_\_\_

Expiration date \_\_\_\_\_  
(cannot exceed one year)

Participant signature \_\_\_\_\_

Guardian signature (if applicable) \_\_\_\_\_

Witness \_\_\_\_\_  
(optional)