



# Supported Decision Making Referral Form

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

## Supported Partner Information

Full Name: \_\_\_\_\_ AKA: \_\_\_\_\_  
*Last First M.I.*

Address: \_\_\_\_\_  
*Street Address Apartment/Unit #*

City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_  
Is this Home Controlled by a Provider of Supports? \_\_\_\_\_ Lived here how Long? \_\_\_\_\_

Name of Provider: \_\_\_\_\_ Primary Contact: \_\_\_\_\_

Contact Address and Telephone: \_\_\_\_\_

Describe Formal Supports Received: \_\_\_\_\_

Does this person have a Guardian or existing Power of Attorney? \_\_\_\_\_

If yes, Name and Contact Information (attach documents) \_\_\_\_\_

Contact information of closest family and/or friends: \_\_\_\_\_

Contact information for Support Coordinator or Case Manager: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex \_\_\_\_\_ Race \_\_\_\_\_

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

Benefits: \_\_\_\_\_ Social Security/SSI: \_\_\_\_\_ HCBS Waiver: \_\_\_\_\_

Method of Communication: \_\_\_\_\_

Is He/ She a citizen of the United States? YES  NO  Does this Person have Burial Insurance? YES  NO   
If yes, please provide

Is there a Representative Payee? YES  NO  If yes, who? \_\_\_\_\_

Is there a History of Criminal Activity or YES NO

Convictions?

If yes, explain: \_\_\_\_\_

**Referred by**

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

Role of Person referring: \_\_\_\_\_

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

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

**Reason for Referral**

*Please describe circumstances or situations which could be benefited from Supported Decision-Making*

\_\_\_\_\_  
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**Releases of Information Needed**

- |   |  |
|---|--|
| <input type="checkbox"/> SUPPORT COORDINATION / CASE MANAGEMENT | <input type="checkbox"/> REPRESENTATIVE PAYEE      |
| <input type="checkbox"/> PROVIDER OF SUPPORTS / SERVICES        | <input type="checkbox"/> SCHOOL OR TEACHER         |
| <input type="checkbox"/> ATTORNEY                               | <input type="checkbox"/> FAMILY MEMBER AND FRIENDS |
| <input type="checkbox"/> BANK OR OTHER FINANCIAL INSTITUTION    | <input type="checkbox"/> HEALTH CARE PROVIDER      |
| <input type="checkbox"/> EMPLOYER                               | <input type="checkbox"/> MDRS                      |
| <input type="checkbox"/> GUARDIAN OR CONSERVATOR                | <input type="checkbox"/> _____                     |
| <input type="checkbox"/> _____                                  | <input type="checkbox"/> _____                     |

Submit form to: Hilary Colerick  
[Hilary@arcms.org](mailto:Hilary@arcms.org) or fax 228-687-8452