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

☐	SUPPORT COORDINATION / CASE MANAGEMENT	☐	REPRESENTATIVE PAYEE
☐	PROVIDER OF SUPPORTS / SERVICES	☐	SCHOOL OR TEACHER
☐	ATTORNEY	☐	FAMILY MEMBER AND FRIENDS
☐	BANK OR OTHER FINANCIAL INSTITUTION	☐	HEALTH CARE PROVIDER
☐	EMPLOYER	☐	MDRS
☐	GUARDIAN OR CONSERVATOR	☐	_____
☐	_____	☐	_____

Submit form to: Hilary Colerick
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