



## APPLICATION/REFERRAL FORM

Name: _____	Record Number: _____
Social Security Number: _____	Date of Birth: _____
Medicaid Number: _____	Date of Screening: _____
Ethnicity: _____ Sex: _____ "This is an Equal Opportunity Program"	

**LIVING ARRANGEMENTS & GUARDIANSHIP**

Contact Person Where Consumer Resides: \_\_\_\_\_

Address of Residence: \_\_\_\_\_

Telephone Number(s): \_\_\_\_\_

Transportation will be provided by: \_\_\_\_\_

Guardianship, if any: \_\_\_\_\_ Relationship to Consumer: \_\_\_\_\_

Case Manager: \_\_\_\_\_ Number: \_\_\_\_\_ Email: \_\_\_\_\_

Case Management Company: \_\_\_\_\_

**EMERGENCY CONTACT and MEDICAL INFORMATION**

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

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

Medical Concerns: \_\_\_\_\_

HarvestWorks to administer meds: \_\_\_\_\_ If yes, Dr.'s order requested on: \_\_\_/\_\_\_/\_\_\_

Self Administering of meds: \_\_\_\_\_ Date of Annual Physical: \_\_\_/\_\_\_/\_\_\_

Signature of person completing this form: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_ Record Number: \_\_\_\_\_

**PROBLEMS/NEEDS**

Vocational Needs: \_\_\_\_\_

Social Needs: \_\_\_\_\_

Behavioral Needs: \_\_\_\_\_

Communication Techniques: \_\_\_\_\_

Other Needs: \_\_\_\_\_

Previous work experience: \_\_\_\_\_

Previous services received: \_\_\_\_\_

Current services/agencies involved: \_\_\_\_\_

**APPLICABLE SERVICES** (requesting to be provided by HarvestWorks)

<input type="checkbox"/> Developmental Therapy	<input type="checkbox"/> Respite
<input type="checkbox"/> Home & Community Supports	<input type="checkbox"/> Personal Care
<input type="checkbox"/> Day Supports	<input type="checkbox"/> Other: _____

**CHOICE**

Has a tour of our facility been given? \_\_\_\_\_

Does consumer choose HarvestWorks to provide services? \_\_\_\_\_

If yes, Why does consumer want to come to HarvestWorks? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**DIAGNOSES**

	Diagnoses Code	Diagnoses	Description
Axis I	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Axis II	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Axis III	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Signature of person completing this form: \_\_\_\_\_ Date: \_\_\_\_\_

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

Record Number: \_\_\_\_\_

Additional Information: \_\_\_\_\_  
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How did the consumer hear about HarvestWorks?  
\_\_\_\_\_

How did the person completing this form hear about HarvestWorks?  
\_\_\_\_\_  
\_\_\_\_\_

Note: Prior to admission assessment date all necessary documentation for charts, service orders, and current goal plans are required. Schedule for consumer will need to be determined based on services and the hours the consumer will be receiving. Hiring, training, and/or in-service of new and current staff must take place prior to admission date.

Please visit our website for the *Medical Form* and the *Admissions Checklist* or contact Jeff Adams at 704-471-0606.

Fax all documents to **704-480-8555** attention **Jeff Adams**. Please call prior to faxing confidential information to inform us in advance that you will be sending us a fax.

[WWW.HARVESTWORKSINC.ORG](http://WWW.HARVESTWORKSINC.ORG)

Signature of person completing this form: \_\_\_\_\_ Date: \_\_\_\_\_