



APPLICATION/REFERRAL FORM

| | |
|-------------------------------|--------------------------|
| Name: _____ | Record Number: _____ |
| Social Security Number: _____ | Date of Birth: _____ |
| Medicaid Number: _____ | Date of Screening: _____ |

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)

- Developmental Therapy
- Home & Community Supports
- Day Supports
- Respite
- Personal Care
- 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: _____

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

Signature of person completing this form: _____ Date: _____