Envision
Creative Support for People with Developmental Disabilities

Referral and Application Form

Date of Referral: ______________________ Referred by: ______________________________________

Name: ____ Sex: M ___ F ___ DOB: ______________
First Middle Last

Current Address: ____ Phone:__________________
Street/P.O. Box City County State Zip Code

SS# _______________________ Medicaid # _______________ Medicare # ______________________

School District of financial responsibility:____

Current Living Arrangements: _________________ Legal/Court Appointed Guardian: No _____ Yes _____

Guardian(s): ____ Relation: _______________________
First Last

Address: ____
Number/Street City State Zip

Phone: __________________________ _________________________ _____________________
Home Work Other]

Language in Home: English ____ Spanish _____ Other (specify) ______________________________

Reason for Referral (area(s) of concern): ____

Transferring from another CCB? No ____ Yes ____ If yes, from: ______________________________

Suspected Disabilities	Diagnosed by	Date

PRIOR EVALUATIONS: (Indicate if the applicant has ever had an adaptive behavior evaluation and/or separate psychological testing.)

Provider: _____________________ Address: ___________________________ Date: ________________

Provider: _____________________ Address: ___________________________ Date: ________________

If under age 5, please complete the following:

Has child ever had any screening: No ____ Yes ____ Date: _____________ Where: __________________

Has child ever had any evaluation/testing done: No ___ Yes ___ Date: __________ Where: ______________

Does the child need evaluation: No ___ Yes ___ School District __________________________________

Is the child categorically eligible based on Part C guidelines: No _____ Yes _____

Reason/Diagnosis: ____

____

Health Coverage: Private Insurance ____ Company: ____
No coverage ____ Unknown ____ Medicaid ____ (HMO ____ or PPO ____)

Physician: ____
Name Address City Zip

CURRENT FAMILY INFORMATION:

____Father ____Stepfather ____Foster Father ____Other

Name:________________________________ Address:________________________________

Home Phone: __________________________ Work Phone: ___________________________

Occupation:____

Current Status:______________________ (i.e.: married, divorced, deceased, etc.)

____Mother ____Stepmother ____Foster Mother ____Other

Name:________________________________ Address:________________________________

Home Phone: __________________________ Work Phone: ___________________________

Occupation:____

Current Status:______________________ (i.e.: married, divorced, deceased, etc.)

BIOLOGICAL FAMILY INFORMATION (IF DIFFERENT):

Mother:________________ Address:__________________________ Phone:_____________

Father:________________ Address:__________________________ Phone:_____________

Current Involvement:____

PERSON TO BE NOTIFIED IN CASE OF EMERGENCY:

Name:____________________________________ Relationship:_______________________

Home Telephone:______________________ Business Telephone:__________________

Address:____

RELATIVES/SIGNIFICANT PERSONS:

Name	Relationship	Birthdate (Siblings)

EDUCATION, THERAPY, EMPLOYMENT HISTORY AND RESIDENTIAL SERVICES: (List all schools and/or other agencies with whom applicant has been or is currently involved. For example: Social Services.)

Agency/Provider	**Address**	**Contact Person**	**Phone**
Social Services			
State Rehabilitation			
Mental Health			
ARC			

Other: (list below – School District, Hospital, etc.)

FINANCIAL INFORMATION / Monthly Income:

Social Security Claim, # if different from S.S. #:____

Social Security Benefit………………………………………………………………….$_______________
SSI Benefits……………………………………………………………………………$_______________
TANF Benefits…………………………………………………………………………$_______________
Other Assets (savings, checking, trusts, etc.) ……………………………………..$_______________

If age 18 or older, please complete the following:

HAVE YOU (APPLICANT) EVER BEEN INVOLVED WITH THE CRIMINAL JUSTICE SYSTEM? IF YES, WHAT WERE THE CIRCUMSTANCES:

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____

OTHER INFORMATION THAT MAY BE HELPFUL IN UNDERSTANDING THE NEEDS OF THE APPLICANT:

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Pursuant to CRS 27-10.5-106, I hereby make application for services from Envision for_________________ _________________________, age __________. I hereby give my permission to perform such evaluations or gather such information necessary to determine eligibility for services through the Colorado Developmental Disabilities System.

_____________ ____

Date Applicant/Parent/Guardian/Auth. Representative

_____________ ____

Date Witness

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