DEVELOPMENTAL DISABILITIES REFERRAL

DEPARTMENT OF HEALTH AND HUMAN SERVICES
AGING SERVICES
SFN 1573 (4-2023)

Clear Fields

Contact Name			Telephone Number
Facility Name			
Address	City	State	ZIP Code

Individual's Name			Telephone Number
Address	City	State	ZIP Code
Gender ☐ Male ☐ Female	Date of Birth	Race	
Language	Medicaid Number	Admission Date	
Is the individual moving into a residence with 4 or more unrelated individuals? ☐ Yes ☐ No			
Individual's New Address	City	State	ZIP Code

Developmental Disabilities Program Manager Name		Telephone Number
Email Address	ICF/IID Level of Care Screen Date (Case Action Start Date)	

Do you have a guardian/legal representative? ☐ Yes ☐ No	If yes, Specify Type ☐ Full ☐ Limited ☐ Conservatorship		
Guardian/Legal Representative Name (Business-if applicable)	Email Address		Telephone Number
Address	City	State	ZIP Code

Do you have a Durable Power of Attorney? ☐ Yes ☐ No			
Durable Power of Attorney Name (Business-if applicable)	Email Address		Telephone Number
Address	City	State	ZIP Code

Would you like a housing facilitator to assist you? ☐ Yes ☐ No	Will the provider be making the purchases? ☐ Yes ☐ No If yes, who:

When returning form, include these documents:
☐ Most Current Overall Service Plan ☐ Most Current Overall Risk Management Assessment Plan

Internal Office Use Only

Date Referral Received	Approved ☐ Yes ☐ No	Date Approved/Denied
Reason Denied		
MFP Staff Signature		Date Assigned in Therap