NEW BEGINNINGS ENTERPRISES, INC. CDDO

SERVICE REFERRAL

Person Referred_____ DOB_____ Phone_____

Social Security Number_____

Address _____

_____

Guardian (if applicable)_____ Phone_____

Address _____

_____

Contact Person's Name_____ Relationship to applicant_____

Address _____ Phone_____

_____

SERVICES(S) REQUESTED:

_____**Residential/Supportive Home Care** - Provides help to people where they live, a family home for children who can no longer live with their natural family.

_____**Day** - Activities during the day, can be recreation, self-care, etc.

_____**Employment Services** - Help in finding and learning job

_____**Respite Services** - Temporary care for people with disabilities who live in the family home

_____**Service Coordination** - Assistance in getting services that will increase independence, can include assistance in accessing public services such as SRS and Social Security, help in determining and obtaining wants and needs.

I am interested in MR/DD services and I consent for the above information and information needed to determine eligibility to be released to New Beginnings Enterprises, Inc. CDDO from the referral agency. This consent expires one year from the date signed unless specified.

_____ _____

Person's Signature Date

_____ _____

Parent/Guardian Date

_____ _____

Referral Signature Date

_____

Referral Agency

Date of initial referral_____ Date of sheet received (CDDO)_____

Directions: To be completed with the person and/or guardian by the community service provider contacted for services. The agency will send the completed sheet, along with available MR/DD documentation to New Beginnings Enterprises, Inc., CDDO Liaison, P.O. Box 344, Neodesha, Kansas 66757, within (5) five working days of initial referral.