

**Selective Case Management, Inc.**

*Disability Services & Solutions*

|  |  |  |
| --- | --- | --- |
| **SERVICE REFERRAL FORM** | **Date Received:** |  |
| **SCM File No:** |  |
| **Assigned To:** |  |
| **\* To be completed by SCM Administrative Staff** | |

|  |  |  |  |
| --- | --- | --- | --- |
| Customer Name: |  | Referring Counselor: |  |
| Address:  *current or permanent?* |  | Agency/Location: |  |
| Phone: |  |
| Phone: |  | Email: |  |
| Email: |  | Authorization Type: |  |
|  |  | Pre-ETS | NO  YES |
| Preferred method of contact: | PHONE TEXT EMAIL | Authorization #: Date it Expires: |  |
| Date of Birth: | *If customer is a minor, or has a legal guardian please include name, relationship and contact information.* | | |
| Diagnosis/Disability: | *Please include known physical restrictions.* | | |
| Reopen File: | NO   |  |  |  | | --- | --- | --- | | Work Experience | Job Placement | Job Readiness |   YES *Customer has previously received the following services from SCM:* | | |
| Services Requested: | | Assessment Needs: | |
| *Please check all that apply*  **Pre-Employment/Job Readiness**  **Site Development/Work Experience**  **Job Development/Placement**  **Job Coaching/Skills Training**  **Employer of Record** | | *Work related areas including*  **Behavior**  **Skills**  **Ethics**  **Transportation**  **Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |
| Customer’s Education and/or Employment Goal/s: | | | |
|  | | | |
| **Accommodations:** | | Does Customer have a(n):  **IEP** NO YES  **IPE** NO YES | |
| **Additional Information/Comments:** | | | |
|  | | | |