

**Selective Case Management, Inc.**

*Disability Services & Solutions*

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| **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:** |
|  |