**Developmental Disability Service Division**

**Group Home Referral Form**

**Date:**

**Group Home/Agency:**

**Name:** **DOB:**

**Does she/he/they agree with group home referral? ☐Yes ☐No ☐Unsure**

**Guardian:**

**Phone Number**

**Does guardian approve of Group Home referral? ☐Yes ☐No ☐ Not applicable**

**Designated Agency:**

**Current Agency Providing Supports:**

**Contact Name** **Phone Number**

**Email**

**Check off all that apply in below sections**

**Special Care Procedures: Yes ☐ No ☐**

**Details:**

**Communication Support Needs:**

**Mobility:**

☐**Independent** ☐**Cane** ☐**Walker** ☐**Wheelchair** ☐ **Other**

**Details:**

**Self-Care Support Needs:**

☐**Independent** ☐**Verbal prompts** ☐**Physical Assistance** ☐**Total Care**

**Details:**

**Behavioral Support Needs:**

☐**Public Safety Risk** ☐**Risk to other residents** ☐**Self-Harm risk** ☐**Other**

**Details:**

**Legal Status:**

☐**Act 248** ☐**Probation** ☐**Other** ☐**None**

**Details:**

**Current Funded Supports:**

| Type | Amount | Funding | Comments |
|---|---|---|---|
| **Service Coordination** | | | |
| **Community** | | | |
| **Employment** | | | |
| **Clinical:** | | | |
| **Supportive:** | | | |
| **Crisis:** | | | |
| **Home:** | | | |
| **Respite Hourly** | | | |
| **Respite Daily** | | | |

**What needs are not being met by current support model?**

**What other supports or support models have been explored to meet these unmet needs?**

**Why is this person being referred to group home setting? Add text box**

**<u>Check off completed tasks:</u>**

☐**Person has been found eligible for DDSD services**
☐**Needs Assessment reflects need for group home level of support**
☐**Medication List and Emergency Fact Sheet attached**
☐**Special Care Procedures attached**
☐**Behavioral Support and Community Safety Plans attached if applicable**
☐**Communication Support Plan attached**