



INITIAL REFERRAL/APPLICATION FORM
Submit via email to Intakes@DominionWaiver.com
Submit via fax to: 540-371-5800 (Fredericksburg Location)
Submit via fax to: 804-266-9022 (Richmond Location)

Service(s) being requested:

- In-Home Residential Support Group Day Community Engagement
 Independent Living Shared Living Sponsored Residential

General Information:

Applicant name: _____

Date of birth: _____ Gender: _____

Address: _____

Primary Phone: _____ Alternate Phone: _____

Email Address: _____

Diagnosis: _____

Medicaid Waiver Type: CL FIS BI

Individual Medicaid#: _____

Legal Guardian or Authorized Representative: _____

Relationship: _____

Address: _____

Primary Phone: _____ Alternate Phone: _____

Referring Information:

Referral Source: _____

Support Coordinator/Case Manager: _____

Phone #: _____ Fax #: _____

Email: _____



Medical Information:

Current Health Problems, Complaints and/or Disabilities not listed previously:

Past Serious Health Problems:

Current Medications:

Medication	Dosage	Why Prescribed

Specific Areas of Interest:

Check the areas that the individual is most interested in learning about while receiving services:

- Self-knowledge and self-determination
- Self-advocacy
- Problem solving
- Choice making
- Communication and conversation skills
- Social behavior
- Handling difficult feelings and situations/conflict resolution
- Basic computer skills
- Job seeking skills
- Time management
- Handling money and making purchases
- Navigating the community
- Safety and home and in the community
- Pre-vocational skills
- Assistance with medical needs
- Assistance with mental health or emotional needs
- Assistance with personal care needs
- Other: (explain below)



Reason for referral including presenting needs and preferences: _____

Number of hours requested: _____

Documentation Needed along with referral form:	Date of Report	Date Received (DWS Office use)
Psychological or other diagnostic report indicating diagnosis of intellectual disability and/or developmental disability		
SIS		
Plan Of Care, Essential Info, Shared Planning, Personal Profile		
Eligibility for Medicaid Waiver funding		

Referral Source Name: _____

Signature: _____ Date: _____

For DWS office use only:

Date referral received: _____

Date of initial contact: _____

Date of first interview: _____

Approved for services: _____

Not approved/ referred to other agency(list agency): _____
