DDM Screening and Referral Information Date of Request

Potential Participant Name _____

Current Address _____

Contact Number(s) _____

Age _____ Gender: _____

Type of Service Needed (Check all that apply):

- ☐ Group Home
- ☐ Sponsored Residential
- ☐ Respite Care

Location Preference (check all that apply):

- ❑ Salem
- ❑ Richmond
- ❑ Bedford County
- ❑ Abingdon
- ❑ Fredericksburg
- ❑ Virginia Beach
- ❑ Martinsville
- ❑ Farmville
- ❑ No Preference

Caller/Informant Name _____

Relationship _____

Address _____

Phone Number _____

Diagnosis:

Reason the applicant is requesting services:

Funding Source: If waiver, which waiver _____
Other:

Is this person receiving services from a Community Service Board? If yes please provide the contact information for the Service Coordinator:

Presenting Needs (Include brief personal care, medical and behavioral needs):

Recommendations/Actions Taken:

Further contacts needed at this time: