



Evidence Based Supported Employment

REFERRAL FOR SERVICES Fax Attn: Ashley Alhambra St. Mary's County Fax: 240-309-4160

I. DEMOGRAPHICS

Name: _____ SSN: _____

DOB: _____ Sex: _____ Applicant lives with: spouse child parent(s) alone other _____

Address: _____ Phone: _____

Directions to Residence: _____

Marital Status: _____ Children & Ages: _____

Last completed grade/level of education: _____ Occupation: _____

II. FISCAL INFORMATION

Does applicant have: Yes No Pending

Medical Assistance _____ Number: _____ Dates: _____

SSDI/SSI _____ Amount: _____

Earned Income _____ Average Monthly Income: _____

Food Stamps _____ Amount: _____

Insurance _____ Type: _____

Other _____ Type: _____

III. REFERRAL INFORMATION

Person Making Referral _____ Phone: _____

Name and Address of Agency: _____

Emergency Contact Person: _____ Phone: _____

Therapist: _____ Phone: _____

Case Manager: _____ Phone: _____

Medical Doctor: _____ Phone: _____

Psychiatrist: _____ Phone: _____

IV. PSYCHIATRIC HISTORY

Current diagnosis:

Axis I _____ Axis II _____

Axis III _____ Axis IV _____

Axis V: GAF _____ Date of Assignment _____

Person Completing Form

Date Received