Thriveora Community

CONSULTATION REFERRAL FORM

Please complete the following and attach all supporting documentation with referral submission. Referral packets can be e-mailed to: info@thriveora.org

1. Client Information

Service Requested: [ ] Community Coaching (1:1) [ ] Community Engagement	
Individual's Name:	Date of Birth (MM/DD/YYYY):
Address & Suite/Apt:	City, State, Zip Code:
Medicaid ID Number:	Waiver Type: [ ] FIS [ ] CL [ ] BI
Primary Diagnoses:	

2. Brief Reason for Referral & Community Goals

Detail specific community integration outcomes, safety concerns, or skills to build:

3. Legal Decision-Making Status

Is the individual their own legal decision-maker? [ ] Yes [ ] No	
Decision-Maker's Name:	Phone Number:
Email Address:	Authority Type: [ ] Self [ ] POA [ ] AR [ ] Guardian [ ] Other

4. Case Management & Care Network

Case Manager Name / Support Coordinator:	CSB / Agency Affiliation:
Case Manager Email Address:	Case Manager Phone Number:
Residential/Home Contact Info:	Day Support / Employer Contact Info:

5. Supporting Documentation Required Checklist

Please review and attach the following items with your referral submission:

[X] Individualized Service Plan (ISP) - Required
[X] Guardianship / Power of Attorney (POA) Documentation (if applicable)
[ ] SIS / VIDES Assessment Records
[ ] Psychological Evaluation(s) / Medical History Summaries

Please complete form and email alongside documentation to: info@thriveora.org

Please call 571-383-0026 with questions