The Arc of Chemung
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Achieve with us.

For people with intellectual and developmental disabilities

AGENCY REFERRAL FORM

NAME:
(Last) (First) (M.I.)

ADDRESS:
(Street) (City) (State) (Zip)

COUNTY:	PHONE:
GENDER MALE FEMALE	DATE OF BIRTH:

ADVOCATE OR LEGAL GUARDIAN NAME:
(Last) (First) (M.I.)

ADDRESS: PHONE:

SERVICE COORDINATOR: (or person assisting the individual, if appropriate)

ETHNIC: White Black Asian or Pacific Islander American Indian/Alaskan
Other (specify):______________________________

PROGRAMS REQUESTED:

____ Residential	____ Overnight Respite
____ Vocational Services	____ Family Reimbursement
____ Medicaid Service Coordination	____ Day Habilitation
____ Family Member Training	____ Community Habilitation
____ Developmental Health Services	____ Hourly Respite (Youth, Summer or After School)
____ Recreation	____ Other: ______________________________

SOCIAL SECURITY #: MEDICAID NUMBER: MEDICARE NUMBER: OTHER INSURANCE:

CHAPTER 620: Yes No SSI: Yes No SSA: Yes No
VA Benefits: Yes No Other:______________________________

GUARDIANSHIP STATUS: Independent NYSARC Other (Specify): ______________________________

PRIMARY DISABILITY: Autism Cerebral Palsy Epilepsy Intellectual Disability
Mental Health Neurological Impairments Other:______________________________ To be Determined

SECONDARY DISABILITY (if applicable): Autism Cerebral Palsy Epilepsy Intellectual Disability
Mental Health Neurological Impairments Other:______________________________ To be determined

PERSON/AGENCY REFERRING:	DATE: