Care Connect of Virginia, LLC

Referral Form

Date of Referral: _____ Referral for: _____
(program)

Individual Being Referred

Individual's Name: _____ Gender: _____ DOB: _____

Medicaid Number: _____ Medicare Number: _____

Current Address: _____

_____

Primary Phone Number: _____ Secondary Phone Number: _____

Social Security No: _____ Waiver Type: _____

The individual is a competent adult:

Is there a ☐ Legal Guardian ☐ Authorized Rep. ☐ Power of Atty ☐ Payee

Legal Guardian's Name: _____ Relationship to Individual: _____

Address: _____

_____

Primary Phone Number: _____ Secondary Phone Number: _____

Diagnosis: Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: _____

Current Medications: _____

_____

_____

_____

_____

Allergies: _____

Referral Source

Name of Person Referring: _____

Organization and/or Relationship: _____

Address: _____

Phone: _____ Fax: _____

Email: _____

Referrals will not be processed without the following accompanying documentation, some of which this agency may obtain through the WaMS portal:

- ☐ Completed Referral Form
- ☐ Psychological Assessment
- ☐ DSM-V Diagnosis Review
- ☐ VIDES
- ☐ SIS
- ☐ Supplemental Needs/Risk Assessment Survey
- ☐ Plan for Supports, Parts I - IV

Please fax documents to 1-540-301-0769, Attention: Andrea Leonard,
Or through an encrypted email to athomewithcareconnect@gmail.com

For Care Connect of Virginia, LLC, Staff Only to Complete:

Date individual was contacted: _____

Details:

Final Disposition:

Staff Signature: _____ Date: _____