State of Illinois
Illinois Department on Aging

Referral Form for Services and Supports

Referral Date: **Time:** **Agency Name:**

Staff Person Taking Referral:

PERSON MAKING THE REFERRAL:
Name:
Phone: ☐ Cell ☐ Home ☐ Work
E-mail:
Relationship to Individual in need of supports and services:

INDIVIDUAL IN NEED OF SERVICES AND SUPPORTS		
Name:	Age:	Date of Birth:
Address:	City:	Zip Code:
County:	Phone: ☐ Home ☐ Work ☐ Cell	
E-mail:		
If not English-speaking, preferred language:		
Do you live alone? ☐ Yes ☐ No	Safety issues (i.e. dogs)? ☐ Yes ☐ No Please describe:	
If not a home residence, please indicate the name and type of facility where the Individual is located.		
Facility Name:		
Facility Address: ☐ Assisted Living ☐ Supportive Living Program ☐ Long-term Care Facility (Nursing Home) ☐ Hospital ☐ Hospice Facility ☐ Other: Name:		

DOES THE INDIVIDUAL HAVE A SPOUSE? ☐ Yes ☐ No	If yes, Spouse Name:
Is spouse in need of services and supports? ☐ Yes ☐ No	Age of spouse?
Is there a friend/family caregiver or emergency contact that needs to be contacted? ☐ Yes ☐ No	
If yes, provide contact information (if known):	

DOES THE INDIVIDUAL HAVE ANY OF THE FOLLOWING?
Legal Guardian ☐ Yes ☐ No ☐ Unknown
Representative Payee ☐ Yes ☐ No ☐ Unknown
Power of Attorney for Health ☐ Yes ☐ No ☐ Unknown
Power of Attorney for Financial ☐ Yes ☐ No ☐ Unknown
If yes, provide contact information (if known):
Is there a friend/family caregiver or emergency contact that needs to be contacted? ☐ Yes ☐ No
If yes, provide contact information (if known):
Is there any other individual at this residence that needs services and supports? ☐ Yes ☐ No
NOTE: If yes, complete a separate referral form if 60 or over. If under 60, refer to the proper state agency.

Name of other individual (if known):
Age of other individual (if known):

HEALTH INFORMATION:
Does the Individual have: Hearing loss? ☐ Yes ☐ No ☐ Unk. Vision Issues? ☐ Yes ☐ No ☐ Unk.
If yes, preferred method of communication (i.e., Interpreter, TTY Relay Services or Braille Assistance):
Has the Individual been told by a health care professional that they have any of the following?
Alzheimer's or any other type of dementia? ☐ Yes ☐ No ☐ Unknown
Mental Health Illness? ☐ Yes ☐ No ☐ Unknown
Physical Disability? ☐ Yes ☐ No ☐ Unknown
Intellectual/Developmental Disability? ☐ Yes ☐ No ☐ Unknown
Brain Injury (i.e., stroke, head injury, aneurysm)? ☐ Yes ☐ No ☐ Unknown

ADDITIONAL INFORMATION REGARDING THE INDIVIDUAL IN NEED OF SUPPORTS AND SERVICES
Reason for Referral (general concerns): *Please provide any additional information regarding the Individual in need of supports and services that may be helpful.*
Does the Individual receive any supports and services now? ☐ Yes ☐ No If yes, type of supports and services are received:
Is the Individual experiencing any problems with the current supports and services? ☐ Yes ☐ No Please explain:
Has the Individual or spouse served in the military? ☐ Yes ☐ No
Is the Individual aware of the referral? ☐ Yes ☐ No ☐ Unknown
Is the Individual in immediate danger? ☐ Yes ☐ No ☐ Unknown Explain:
Is the Individual in need of immediate assistance? ☐ Yes ☐ No Explain:
Does the Individual want someone else to be present during the home visit? ☐ Yes ☐ No If yes, who:
What would be the best time and method to contact the Individual (if known): Time: Phone: E-mail:

Print **Save** **Clear Form**