dominion waiver services

INITIAL REFERRAL/APPLICATION FORM

Submit via email to Intakes@DominionWaiver.com
Submit via fax to: 540-371-5800 (Fredericksburg Location)
Submit via fax to: 804-266-9022 (Richmond Location)
Submit via fax to: 540-362-0973 (Roanoke Location)

Service(s) being requested:

☐ In-Home Residential Support ☐ Group Day ☐ Community Engagement

☐ Independent Living ☐ Shared Living ☐ Sponsored Residential

General Information:

Applicant name:_____

Date of birth: _____ Gender: _____

Address: _____

Primary Phone: _____ Alternate Phone: _____

Email Address:_____

Diagnosis: _____

_____

Medicaid Waiver Type: ☐ CL ☐ FIS ☐ BI

Individual Medicaid#:_____

Legal Guardian or Authorized Representative: _____

Relationship: _____

Address: _____

Primary Phone: _____ Alternate Phone: _____

Referring Information:

Referral Source: _____

Support Coordinator/Case Manager: _____

Phone #: _____ Fax #: _____

Email: _____

dominion waiver services

Medical Information:
Current Health Problems, Complaints and/or Disabilities not listed previously:

_____
_____
_____

Past Serious Health Problems:

_____
_____
_____

Current Medications:

Medication	Dosage	Why Prescribed

Specific Areas of Interest:
Check the areas that the individual is most interested in learning about while receiving services:

☐ Self-knowledge and self-determination
☐ Self-advocacy
☐ Problem solving
☐ Choice making
☐ Communication and conversation skills
☐ Social behavior
☐ Handling difficult feelings and situations/conflict resolution
☐ Basic computer skills
☐ Job seeking skills
☐ Time management
☐ Handling money and making purchases
☐ Navigating the community
☐ Safety and home and in the community
☐ Pre-vocational skills
☐ Assistance with medical needs
☐ Assistance with mental health or emotional needs
☐ Assistance with personal care needs
☐ Other: (explain below)

dominion waiver services

Reason for referral including presenting needs and preferences: _____

_____

_____

_____

_____

Number of hours requested: _____

Documentation Needed along with referral form:	Date of Report	Date Received (DWS Office use)
Psychological or other diagnostic report indicating diagnosis of intellectual disability and/or developmental disability		
SIS		
Plan Of Care, Essential Info, Shared Planning, Personal Profile		
Eligibility for Medicaid Waiver funding		

Referral Source Name:_____

Signature: _____ Date: _____

For DWS office use only:

Date referral received:_____

Date of initial contact:_____

Date of first interview:_____

Approved for services:_____

Not approved/ referred to other agency(list agency):_____

_____