Job Discovery Inc.
10345 Democracy Lane, Fairfax, Virginia 22030
info@jobdiscovery.org
P: 703-385-0041 • F: 703 385-1113 • TTY: 703-385-3155

Consumer Referral Application Form

For: ☐ Residential ☐ Support Elements

Consumer Name:_____Date:_____Sex:☐/☐

Address: _____

Home Phone: ( ) _____Work Phone: ( ) _____

Social Security Disability Insurance (SSDI):_____Supplemental Security Insurance (SSI): _____

Medicaid #:_____Medicare#: _____

Other Insurance: _____Policy #: _____

Source of Referral:_____Date of Initial Vendor Contact: _____

Reason for Referral:_____

Date of Birth:_____Birth Place: _____

Primary Diagnosis:_____ Date of Diagnosis: _____

Other / Secondary Diagnosis:_____ Date of Diagnosis: _____

Are you a United States Citizen? ☐ Yes ☐ No Race: _____Criminal Justice Status (if any): _____

Legal Guardian (Court Appointed): _____☐ N/A

Address: _____

Home Phone: ( ) _____Work Phone: ( ) _____

Primary Language: _____Secondary Language: _____

Family Composition / Others who Reside with You (relationships)

Father: _____Occupation:_____

Address: _____

Home Phone: ( ) _____Work Phone: ( ) _____

Mother:_____Occupation:_____

Address: _____

Home Phone: ( ) _____Work Phone: ( ) _____

Sibling Name: _____/ Age: _____Sibling Name: _____/ Age: _____

Sibling Name: _____/ Age: _____Sibling Name: _____/ Age: _____

Other Significant Support Systems: _____

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Family/Emergency Contacts (other than parent or doctor)

Name:_____Relationship: _____

Address: _____

Home Phone: ( ) _____Work Phone: ( )_____

Name:_____Relationship: _____

Address: _____

Home Phone: ( ) _____Work Phone: ( )_____

Day Supporting Funding Source

Medicaid State Plan Option: _____Medicaid Waiver:_____CSB: _____

Other: _____

Consumer Preferences and Behavioral Information

Residential Preference: ☐ Group Home ☐ Apartment Living

Vocational / Employment Interests (Type of Work) : _____

Special Dietary Needs:_____

Current Living Needs: _____

Current Living Arrangement: _____
(Home, Apartment, Group, Home, Institution, Etc.)

Name of Case Manager:_____Phone Number: ( )_____

Name of DRS Counselor: _____Phone Number: ( )_____

Currently Attends Day Program: ☐ Yes ☐ No

Describe any concerns or issues that may affect your daily participation in a day support / employment services program:

_____

_____

Communication: (Check Yes or No)

Uses Sounds/Gestures: ☐ Yes ☐ No
Uses Key Words/Signs: ☐ Yes ☐ No
Speaks Clearly: ☐ Yes ☐ No
Intelligible to Strangers: ☐ Yes ☐ No

Transportation: (Check Yes or No)

Transportation Available: ☐ Yes ☐ No
Lives on Bus Route: ☐ Yes ☐ No
Family Available to Transport: ☐ Yes ☐ No
ovides own Transportation: ☐ Yes ☐ No

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Behavioral History:

History of oppositional/defiant behavior, ignores rules or regulations? ☐ Yes ☐ No

History of wandering/leaving for long periods of time/running away? ☐ Yes ☐ No

Difficulty respecting boundaries/taking others' belongings? ☐ Yes ☐ No

Removes or tears off clothing? ☐ Yes ☐ No

Displays sexually inappropriate behavior (eg. inappropriate touching)? ☐ Yes ☐ No

History of use of profane or hostile language? ☐ Yes ☐ No

History of physical violence to self or others? ☐ Yes ☐ No

Please Attach the Following Information to the Referral Form and Submit to Job Discovery Inc.

1. Psychological Evaluation
2. Social History
3. Current ISP, ICAP
4. Medical History
5. Medication Administered
6. Documentation of Guardianship
7. Record of Immunization/Prevention (Hepatitis, TB test, Flu, Tetanus, etc.)
8. Criminal Background History Report

Please share any comments in the space below or attach any other documents that might be helpful in Job Discovery Inc.'s review of this packet:

_____

_____

_____

_____

_____

Thank you,
Job Discovery Inc.

Person Completing Form:_____

Title: _____

Phone: ( ) _____

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