



### Referral Form

Please complete the information below and email to [kollynewetzel@penn-mar.org](mailto:kollynewetzel@penn-mar.org) or fax to 410-343-1770. A PMHS representative will contact you promptly regarding your referral.

REFERRAL INFORMATION			
Applicant Name		Birth Year	
<b>What type of supports is the applicant interested in? (Check All that Apply)</b> <input type="checkbox"/> Social Connections <input type="checkbox"/> Navigating Community Resources <input type="checkbox"/> Employment Development & Support <input type="checkbox"/> Residential: <input type="checkbox"/> Respite (approx. # days) <input type="checkbox"/> Independent Living Skills (Specify): <input type="checkbox"/> Personal Care <input type="checkbox"/> Financial & Benefits Management <input type="checkbox"/> Participation in Activities of Interest <input type="checkbox"/> Supervision <input type="checkbox"/> Health <input type="checkbox"/> Communication & Behavioral Support <input type="checkbox"/> Peer Support <input type="checkbox"/> Other (Specify):			
<b>What are the outcomes you or your family is seeking to achieve through Penn-Mar's services?</b>  			
<b>What skills, abilities and interests do you have?</b>  			
<b>What natural supports are involved in your life?</b>  			
<b>What transportation resources do you use?</b>  			
<b>Summary of Disability/Diagnosis (if applicable):</b>  			
Name of Referral Contact		Relationship	
Referral Contact Phone		Referral Contact Email	
<b>Where are you from?</b> <input type="checkbox"/> School, TY Year: <input type="checkbox"/> New to Services <input type="checkbox"/> Adult Agency (specify):			
<b>Funding for Services?</b> <input type="checkbox"/> Community Pathways <input type="checkbox"/> Family Supports <input type="checkbox"/> Community Supports <input type="checkbox"/> State Only Funds <input type="checkbox"/> Other (Specify):			
Address			
City, State, ZIP		County	
<b>Who do you live with?</b> <input type="checkbox"/> Residential Provider (specify):		<input type="checkbox"/> Family <input type="checkbox"/> Independently <input type="checkbox"/> Other Caregiver (specify):	
Family/Caregiver Name(s)			
Primary Phone		<input type="checkbox"/> cell <input type="checkbox"/> home <input type="checkbox"/> work	
Email			
Coordinator of Community Services		CCS	CCS E-mail      CCS Phone