IMPACT Community Services, LLC.
Referral Form
(645)

Date of Referral: _____

Individual's Name (Full):_____ **Gender**: M or F **DOB**: _____

Medicaid #:_____ **Medicare #**:_____

Currently Address: _____

Individual initiating the referral:

- ☐ Self
- ☐ Support Coordinator:_____ CSB:_____
- ☐ LAR:_____
- ☐ Family Member:_____ Relation:_____
- ☐ Other: _____ Relation:_____

Type of service needed:

- ☐ Sponsored Residential Service

Location preference:

- ☐ Chesterfield VA
- ☐ Richmond VA
- ☐ Henrico VA
- ☐ Chester VA

Individual currently receiving the following:

- ☐ ID Waiver (Residential Services & Day Support)
- ☐ ID Waiver (Day Support)
- ☐ ID Waiver (Respite Services)
- ☐ DD Waiver

Diagnosis:
Primary: _____

Secondary: _____

Behavioral concerns:

_____

_____

_____

Reason for referral:

_____

_____

_____

Significant Limitations in the Following Areas:

- ☐ Communication
- ☐ Self-Care
- ☐ Domestic Skills
- ☐ Social Skills
- ☐ Money Management
- ☐ Health and Safety

Tentative placement date: _____

Support Coordinator contact information:

Name (full):_____ **Phone#**:_____

Please forward this form along with copies of social/medical history, last psychological evaluation, level of functioning survey, SIS and proof of waiver enrollment to:

IMPACT Community Services, LLC
10310 Memory Lane
Suite 1A
Chesterfield, VA 23832

Office: 804-454-1332 Fax: 866-309-2364 Email: impactcommunityservices@gmail.com Website: impactcomserv.com