Cleveland Vocational Industries Incorporated
WE WORK

APPLICATION/REFERRAL FORM

Name: _____ Record Number: _____

Social Security Number: _____ Date of Birth: _____

Medicaid Number:_____ Date of Screening: _____

Ethnicity: _____ Sex: _____ "This is an Equal Opportunity Program"

LIVING ARRANGEMENTS & GUARDIANSHIP

Contact Person Where Consumer Resides: _____

Address of Residence: _____

Telephone Number(s): _____

Transportation will be provided by: _____

Guardianship, if any: _____ Relationship to Consumer: _____

Case Manager: _____ Number: _____ Email: _____

Case Management Company: _____

EMERGENCY CONTACT and MEDICAL INFORMATION

Name:_____ Telephone: _____

Address: _____

Medical Concerns: _____

CVII to administer meds: _____ If yes, Dr.'s order requested on: ___/___/___

Self Administering of meds:_____ Date of Annual Physical: ___/___/___

Signature of person completing this form: _____ Date: _____

Name: _____ Record Number: _____

PROBLEMS/NEEDS

Vocational Needs: _____

Social Needs: _____

Behavioral Needs: _____

Communication Techniques: _____

Other Needs: _____

Previous work experience: _____

Previous services received: _____

Current services/agencies involved: _____

APPLICABLE SERVICES

- ☐ Day Supports (CAP)
- ☐ Supported Employment (CAP)
- ☐ Personal Care (CAP)
- ☐ Respite (CAP)
- ☐ ADVP (IPRS)
- ☐ Supported Employment (IPRS)
- ☐ Day Activity (IPRS)
- ☐ Community Rehab (IPRS) (*Formerly Sheltered Workshop*)
- ☐ Targeted Case Management
- ☐ Other: _____

CHOICE

Has a tour of our facility been given? _____

Does consumer choose CVII to provide services? _____

If yes, Why does consumer want to come to CVII? _____

_____

_____

_____

DIAGNOSES

	Diagnoses Code	Diagnoses	Description
Axis I			
Axis II			
Axis III			

Signature of person completing this form: _____ Date: _____

Name: _____ Record Number: _____

Additional Information: _____

How did the consumer hear about CVII?

_____

How did the person completing this form hear about CVII?

_____

_____

Note: Prior to admission assessment date all necessary documentation for charts, service orders, and current goal plans are required. Schedule for consumer will need to be determined based on services and the hours the consumer will be receiving. Hiring, training, and/or in-service of new and current staff must take place prior to admission date.

Please visit our website for the ***Medical Form*** and the ***Admissions Checklist*** or contact Jeff Adams at 704-471-0606.

Fax all documents to **704-480-8555** attention **Jeff Adams**. Please call prior to faxing confidential information to inform us in advance that you will be sending us a fax.

WWW.CVII.ORG

Signature of person completing this form: _____ Date: _____

Please occasionally check back for updates to this and other forms. 2/14/2008