



## Referral Form

**Type of Service Request:** *(please check the box for which services you are filling out a referral form for).*

- Adult Day Program  Adult Foster Care  Employment Development  Employment Exploration  
 Employment Support  In-Home Family Support with Training  In-Home Support with Training  
 Positive Support Services  Respite Services

**Client Information:** *(please fill out the following information that would pertain to the client who will be receiving services)*

**Name:** \_\_\_\_\_

**Gender:**  Male  Female

**Date of Birth:** \_\_\_\_\_ **Age:** \_\_\_\_\_

**Social Security Number:** \_\_\_\_\_

**Address:** \_\_\_\_\_  
City State, Zip

**Phone Number:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_

**Type of Waiver:** \_\_\_\_\_

**Waiver Case Manager Information:** *(please fill out the following information that would pertain to the case manager who is responsible for the waiver / billing)*

**Name of Case Manager:** \_\_\_\_\_

**Company Name:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_

**Fax Number:** \_\_\_\_\_



**Legal Representative / Guardian Information:** *(please fill out the following information if the client has a legal representative, a guardian or is under guardianship)*

Does the client have a legal representative, guardian or under guardianship?  Yes *(please proceed to fill out the form)*  No *(skip to the next section)*

Name: \_\_\_\_\_

Relation to client: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Address: \_\_\_\_\_

City

State, Zip

**Care Team / Support System:** *(please fill out the following information and list all over names, relations / titles, and contact information for all care team members and support systems)*

Name	Relation / Title	Contact Information

Thank you for choosing Gateway Unlimited Living LLC Services for your services needs.  
Please email the completed referral form to [inquiries@gatewayunlimitedliving.com](mailto:inquiries@gatewayunlimitedliving.com)