BRIDGES
REMOVING BARRIERS, ADVANCING AUTONOMY

# Community Habilitation Referral Form

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|---|---|
| Referral Agency Name: | Date of Referral: |
| Care Managers Name: | Contact number: |
| Individuals Name: | DOB: |
| Medicaid #: | TABS #: |
| Parent/Guardian Name: | Contact #: |
| Address: | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Community Habilitation approved hours: | Community Habilitation Units approved: | | | | | | |
| Days of the week the family wants services: | **Mon** ☐ | **TUES** ☐ | **WED** ☐ | **Thurs** ☐ | **Fri** ☐ | **Sat** ☐ | **Sun** ☐ |

| **Documents provided** | Yes | No |
|---|---|---|
| Psychological | ☐ | ☐ |
| Psychosocial | ☐ | ☐ |
| NOD (Notice of Decision) | ☐ | ☐ |
| Life Plan | ☐ | ☐ |
| Addendum | ☐ | ☐ |


| | | |
|---|---|---|
| Physical | ☐ | ☐ |
| Approval Letter | ☐ | ☐ |