Day Supports/Employment Services Referral

Contact Information

Name of the Person: ________________________________ Date: __________________

Current Enrollments: ____ DDS ____ MRC

Best Days/Times to Meet: __ M __ T __W __Th __ Fr __ AM __ PM

Current Programs (If Any): ____

____

Person making Referral: ___________________________ Title: __________________

Contact Number: ___________________________ Email: ______________________________

Has the Individual Been Referred Before: ___ Yes ____ No

If Yes, When? __________________________ Program Type: ______________________

Individual Lives: ___ At Home ___ Group Home ___Shared Living ___ On their Own

Name of DDS Service Coordinator (if applicable): __________________________________

Contact Number: ___________________________ Email: ______________________________

Work History

Past Work Sites (if any)

1. Site Name: ___________________________ ___ Paid ___ Volunteer

   Tasks:____

   ____

   ____

2. Site Name: ___________________________ ___ Paid ___ Volunteer

   Tasks:____

   ____

   ____

3. Site Name: ___________________________ ___ Paid ___ Volunteer

   Tasks:____

   ____

   ____

Favorite Work Site: ____

Return Completed Form by Fax: 508.778.4919; email: jskolnick@lifecapecod.org; by mail to LIFE, Attention Josh Skolnick, 550 Lincoln Road Ext., Hyannis, MA 02601

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Has the Individual Expressed a Desire to Work Somewhere Specific? ___ Yes ___ No

If Yes, Where, Doing What? ____

____

____

Travel Trained: ___ Yes ___ No

If Yes: ___ Overall ___ From:______________________ To: ______________________

Mode: ___ Public Bus ___ Cab/Uber/Lyft ___ Walking ___ ADA

Preferred Mode of Communication: ___ Verbal ___ Sign Language ___ Pictures

__ Aug. Device __ Other (Please Describe) ______________________________

____

Interests: ____

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Things to Avoid: ____

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Health/Behavior Concerns: ____

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