

Chemung ARC  
AGENCY REFERRAL FORM

NAME:			
(Last)	(First)	(M.I.)	
ADDRESS:			
(Street)	(City)	(State)	(Zip)
COUNTY:		PHONE:	
GENDER:        MALE        FEMALE		DATE OF BIRTH:	
ADVOCATE OR LEGAL GUARDIAN:			
LAST NAME:		FIRST NAME:	M.I.:
ADDRESS:		PHONE:	
SERVICE COORDINATOR: (or person assisting the individual, if appropriate)			
ETHNIC:        Caucasian        Black        Asian or Pacific Islander        American Indian/Alaskan			
Other (specify)			
PROGRAMS REQUESTED:			
<input type="checkbox"/> Residential		<input type="checkbox"/> Respite	
<input type="checkbox"/> STI		<input type="checkbox"/> Family Reimbursement	
<input type="checkbox"/> Medicaid Service Coordination		<input type="checkbox"/> Seniors Program	
<input type="checkbox"/> ISS Funding		<input type="checkbox"/> Community Residential Habilitation	
<input type="checkbox"/> Developmental Health Services		<input type="checkbox"/> Community Day Habilitation	
<input type="checkbox"/> Recreation		<input type="checkbox"/> Other _____	
SOCIAL SECURITY #:		MEDICAID NUMBER:	MEDICARE NUMBER:
OTHER INSURANCE:			
CHAPTER 620:    Yes    No		SSI:    Yes    No	
VA Benefits:    Yes    No		SSA:    Yes    No	
Other: _____			
GUARDIANSHIP STATUS:		Independent	NYSARC
Other (Specify)			
PRIMARY DISABILITY:		Autism	Cerebral Palsy
Mental Health		Neurological Impairments	Epilepsy
		Other _____	Mental Retardation
To be Determined			
SECONDARY DISABILITY (if applicable):			
Autism		Cerebral Palsy	Epilepsy
Mental Health		Neurological Impairments	Mental Retardation
		Other _____	To be determined
PERSON/AGENCY REFERRING:		DATE REFERRED:	