C.A.R.E. PROGRAM REFERRAL FORM

Date of referral:		*Referral source:*	☐ J.D. McCarty ☐ DHS ☐ QW ☐ DDS ☐Other:
***** Email completed form to care@jdmc.ok.gov*****			
Name of person completing the referral:			
Primary phone:		*Email:*	

Name of individual:		**Date of birth:**	
Address:		**County:**	
KK or Referral Number if applicable:			
Insurance:	☐ SoonerCare/Medicaid ☐ Medicare ☐ Private insurance ☐ Unknown		
DIAGNOSES:			
Diagnosis:		☐ Confirmed with testing ☐ Perceived ☐ Ruled out	
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PARENT / GUARDIAN CONTACT INFORMATION:					
Guardian's name:				**Relationship:**	
Primary phone:		**Secondary phone:**		**Email:**	
Address:					

OKDHS CONTACT INFORMATION:					
CWW name:				**Case status:**	
Primary phone:		**Secondary phone:**		**Email:**	
CWW supervisor:					
Primary phone:		**Email:**			

SOCIAL INFORMATION:			
Household makeup *(list who resides in the home and their relationship to the child):*			
Do any of the other members of the household have a diagnosed or perceived intellectual or developmental disability?	☐ Yes ☐ No ☐ Unknown		
If yes, explain:			
Is there a risk for placement disruption?	☐ Yes ☐ No	**Explain, listing timeframe if possible:**	
Is there a risk for DHS involvement?	☐ Yes ☐ No	**Explain:**	
Are there sensory sensitivities?	☐ Yes ☐ No	**Explain:**	
Current resources / services:	☐ Yes ☐ No	**Explain:**	
List any specific needs the caregiver has identified:			

SUMMARY OF CONCERN:

SPECIAL CONSIDERATIONS: