**C.A.R.E. Program Referral Form**

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| *Date of referral:* |  | *Referral source:* | | | J.D. McCarty  DHS  DDS Other: | |
| ***\*\* Email completed form to care@jdmc.ok.gov\*\**** | | | | | | |
| *Name of person completing the referral:* | | |  | | | |
| *Primary phone:* |  | | *Email:* | | |  |
| *Have you notified the caregiver of this referral?* | | | | Yes  No | | |

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| **Name of individual:** | | |  | | | **Date of birth:** | |  |
| **Address:** |  | | | | | | **County:** |  |
| **KK or Referral Number if applicable:** | | | |  | | | | |
| **Insurance:** | | Unknown  SoonerCare/Medicaid  Medicare  TEFRA  Private: | | | | | | |
| **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:** |  | | | | | | |

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

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| **SOCIAL INFORMATION:** | | | | | | | | |
| **Household makeup** *(list who resides in the home and their relationship to the child/young adult):* | | |  | | | | | |
| **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:** | |  | | |
| **Current resources / services:** | | Yes  No | | **Explain:** | |  | | |
| **List any specific needs the caregiver has identified:** | | | | |  | | | |

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| **SUMMARY OF CONCERN:** |
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| **SPECIAL CONSIDERATIONS:** |
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