**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  |
| **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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