C.A.R.E. Program
Connect. Assess. Respond. Enhance.
OKLAHOMA Human Services
2002 East Robinson
Norman, OK 73071
405-307-2800
care@jdmc.ok.gov
www.jdmc.org

C.A.R.E. Program Referral Form

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		

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:					

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/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:				

SUMMARY OF CONCERN:

SPECIAL CONSIDERATIONS: