Referral Form – Disabilities Services

La Crosse Office

Referral Source:
Participant's Name:
Date of Birth:

Date of Referral:
☐New ☐Revised ☐End

Parent(s)/Guardian:
Home Phone:
Cell Phone:
Address:

Primary Diagnosis:
Secondary Diagnosis:
Initial Goal Areas:
Secondary Goal Areas:
Additional Comments:
Funding source:
☐WWC ☐DVR ☐IRIS ☐Private Pay ☐La Crosse School District ☐Other__________________

Please signify the rate and number of hours approved for:

_______ Hours	☐Week/☐Month	Adult Day Services
_______ Hours	☐Week/☐Month	Daily Living Skills Training
_______ Hours	☐Week/☐Month	Prevocational Services
_______ Hours	☐Week/☐Month	Supported Employment Service
_______ Hours	☐Week/☐Month	Work Experience
_______ Hours	☐Week/☐Month	Job Hire
_______ Hours	☐Week/☐Month	Consult-Supported Employment
_______ Hours	☐Week/☐Month	Consult-Work Experience
_______ Hours	☐Week/☐Month	Consult-Job Hire/Placement
_______ Hours	☐Week/☐Month	90 Day Follow Along Job Retention
_______ Hours	☐Week/☐Month	Job Coaching
_______ Hours	☐Week/☐Month	Assessment

Anticipated start date of service:___/___/___

Fax referral to Renee Pletzer @ 782-0702 or email to rpletzer@cclse.org

Catholic Charities Office: 3710 East Avenue South La Crosse, WI 54602 Phone: (608)782-0710