Referral Form – Disabilities Services

La Crosse Office

Referral Source: Date of Referral:

Participant's Name: ☐New ☐Revised ☐End

Date of Birth:

Parent(s)/Guardian:

Home Phone:

Cell Phone:

Address:

Primary Diagnosis:

Secondary Diagnosis:

Initial Goal Areas:

Secondary Goal Areas:

Additional Comments:

Funding source:

☐CLTSW ☐CCS ☐Juvenile Justice ☐CPS ☐ Private Pay

Please signify the rate and number of hours approved for:

_____ Hours	□Week/□Month	In Home Support
_____ Hours	□Week/□Month	Adult Community Skills Development and Enhancement
_____ Hours	□Week/□Month	Adult Recovery Education and Illness Management
_____ Hours	□Week/□Month	1:5 Rate After School Program
_____ Hours	□Week/□Month	2:5 Rate After School Program
_____ Hours	□Week/□Month	1:1 Rate After School Program
_____ Hours	□Week/□Month	Transition Program
_____ Hours	□Week/□Month	1:5 Rate Summer Day Program
_____ Hours	□Week/□Month	2:5 Rate Summer Day Program
_____ Hours	□Week/□Month	1:1 Rate Summer Day Program

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