Assistive Technology / Home Mod Referral Form

4740 Kingsway Drive, Indianapolis, IN 46205 317-466-2013
www.eastersealscrossroads.org -- tech@eastersealscrossroads.org

Referring Agency Information:

Agency: _____ Phone Number: _____

Name: _____ Email Address: _____

Address: _____ Date of Referral: _____

Client Contact/Demographic Information:

Name: _____ Date of Birth: _____

Address: _____ Phone: _____

_____ Alt Phone: _____

County: _____ Last 4 SSN: _____ Email: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced Gender: ☐ Male ☐ Female ☐ Other

Race: ☐ African Am. ☐ Caucasian ☐ Native Am. ☐ Pacific Islander ☐ Alaskan Native ☐ Hispanic

☐ Multiple Ethnicity ☐ Other: _____

Employment Information (if applicable)

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Retired ☐ Student ☐ Unemployed ☐ Other

Employer: _____ Contact: _____ Phone: _____

Legal Guardian Information:

Does applicant have a legal guardian? ☐ Yes ☒ No If yes, please provide the following information:

Name: _____ Relationship to Client: _____

Address: _____ Telephone: _____

Reason for Referral:

☐ Assistive Technology ☐ Home Modification ☐ Digital Literacy Assessment

☐ Workplace Accommodation ☐ Augmentative Communication

What is the nature of the person's disability?

_____

Are there specific questions or issues that need to be addressed?

_____

What is the planned employment outcome (if applicable)?

_____