Tri · County Care

Intake Referral Form

Individual Name:			**Gender:**
Date of Birth:	**Age:**	**Social Security Number:**	
Diagnosis:		**Preferred Language:**	

TABS ID:	**OPWDD Eligible:** ☐Yes ☐No ☐Unsure
Have you attended the Front Door Orientation? ☐Yes ☐No ☐Unsure	
OPWDD Staff Member/Front Door Contact (if known):	
Medicaid: ☐Yes ☐No	**If Yes, ID# (CIN):**
Child Health Plus: ☐Yes ☐No	**Primary Insurance:**

Street Address:		**County:**
City:	**State:**	**Zip:**
Mailing Address (if different):		

Primary Contact Name:	**Relationship:**
Phone Number:	**Alternate Number:**
E-mail:	

Secondary Contact Name:	**Relationship:**
Phone Number:	**Alternate Number:**
E-mail:	

Primary Care Doctor:
School District:
Hospital:
Dentist:
Pharmacy:
Additional Providers (ie: Developmental Pediatrician, Neurologist, etc):
Additional Active Advocates (ie: grandparents, step-parent, etc):

Please provide the following documents, if available:

- ☐ Any available Psychological Evaluations
- ☐ Adaptive Assessment
- ☐ Autism Evaluation (if applicable)
- ☐ Current Physical
- ☐ Social History Evaluation
- ☐ IEP/504 Plans

These documents will be reviewed to determine if anything additional may be needed.

How did you hear about us:
Any additional information you would like us to know?

The Tri-County Care Application and Consent packet will be generated and sent to you for signatures once we receive the information on this form.