CHILDREN'S DEVELOPMENTAL DISABILITIES SERVICES REFERRAL FORM

Family and Child Information			
Child's Name:		**Date of Request:** Click or tap to enter a date.	
Does the Child have Medicaid?	☐ **No**	☐ **Medicaid Application in Process**	☐ **Yes: MID#:**
Date of Birth: Click or tap to enter a date.	**Age:**	**Child's Diagnosis:**	
Parent/Guardian Name:		**Phone Number:**	
Address:			
Email address:			
Best method to contact parent/legal guardian (email, phone, text):			
If phone, best time to contact parent/guardian:			
Address:			
Primary Spoken Language:			
Current Living Situation: Choose One	**Specify if other:** Click or tap here to enter text.		

Referring Information	
Individual Submitting Referral:	
Phone Number:	**Email:**

What Children's DD services is the family interested in? (Check all that apply)			
☐ **Intervention**	☐ **Community-Based Supports**	☐ **Respite**	☐ **Family Directed Services**
☐ **Family is unsure and would like additional information on all services available**			

Please email this referral form to:

North Hub: katie.rigoli@dhw.idaho.gov West Hub: sarah.allen@dhw.idaho.gov East Hub: heidi.napier@dhw.idaho.gov

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