Disability Assistance Referral

Email completed form(s) to: disabilityreferrals@theservantcenter.org or Fax to: 336-907-3367

Date	*Referring Agency*	*Contact Name & Phone*

APPLICANT INFORMATION

Last Name	*First Name*	*Middle Initial*	*SSN*
Birth Date	*Home Phone*	*Cell Phone*	*MRN*
City & State of Birth	*Mother's Maiden Name (First & Last)*	*Father's Name (First & Last)*	
Alternate Contact	*Alternate's Phone*	*Relationship to Client*	

For Reporting Purposes Only: Race/Ethnicity: Gender: Veteran:

Is the client homeless or at risk of homelessness?

If yes, please complete the homeless verification form and submit with this referral. (Required for SOAR program)

CURRENT ADDRESS *(if homeless, skip this section and to list mailing address below)*

Street Address	*City*	*State*	*Zip code*

MAILING ADDRESS *(if client is homeless or prefers mail be sent to different address)*

Street Address	*City*	*State*	*Zip code*

DISABILITY INFORMATION *(please list all physical and mental health diagnoses)*

Onset Date:

MEDICAID STATUS

Filing (yes or no)? If Yes, Date & Time:

HOSPITALS/INSTITUTIONS *(please list any recent treatment, including psychiatric/behavioral health)*

Name	*Address*	*Date Admitted/Room#*	*Date Discharged*
Name	*Address*	*Date Admitted/Room#*	*Date Discharged*

COMMENTS *(please provide any additional information that will help us serve your client/patient)*

FOR AGENCY USE ONLY: __DAP __SOAR /// TERI? _____

Revised 8/17/2018