Submit by Email

Wall Residences
Valued Lives, Meaningful Living
P.O. Box 235, Floyd, Virginia 24091; 540.745.4216; fax: 540.409.5258; www.wallresidences.com

Date: _____ Person Completing Form: _____

Relationship to Individual:_____

Contact information: Phone:_____ Cell _____ Fax:_____

Email address _____

Referral for:

___ Informational (no DSP selected) ___seeking undecided support/geographic area
___ seeking Sponsored Placement support ___Other (list)

Preferences (if known – please include preferred City/County):_____

_____

Presenting Needs: _____

_____

DEMOGRAPHICS:

Individual's Name: _____Date of Birth: _____

Current Address:_____Gender: _____

Living Arrangements: ___w/ family ___ congregate Sponsored Placement ___ Congregate Group Home ___ Institution (please list)_____

Social Security # _____Medicaid # _____Medicare # _____

Supplement Insurances _____

Is there a Legal Guardian? ___ yes ___ no

If yes, list County, person's name, address and contact numbers_____

_____

Representative Payee information: Name _____Phone:_____

Address:_____

Banking Institution, Account # and balance will be requested prior to transfer. Planning for fundes transfer/ accounting will be made upon acceptance into Wall Residences services

Diagnosis: Axis I:_____ Axis II_____

Funding Source: (ID or DD Waiver, DAP, etc) _____

Follow Up: Date _____ Program Manager _____

Disposition _____

_____

_____

ACCOMPANYING DOCUMENTATION TO BE FORWARDED TO WALL RESIDENCES:

___Consent to Exchange Information ___IDOLS ___Medicaid# ___Medicare Plan card ___LOF ___Social Assessment (Part 1-4) ___Psychological ___Current treating physician ___Current medication list ___Current Physical ___ Current POC

Signed:_____Date:_____

CC: ___WR office ___referring source ___Individual ___Guardian