Referral for Services

Independent Living Program

Fax: 617-202-5245 (Boston Office)

INFORMATION ABOUT THE CONSUMER YOU ARE REFERRING:

Name: _____ **Date of Birth:** _____
Last First Middle

Street Address: _____

Town: _____ **State:** _____ **Zip:** Click here to enter text.

Phone Number: _____ ☐ VP ☐ TTY ☐ voice ☐ fax

Email address: _____ home / mobile / other

Gender: ☐Male ☐ Female ☐ Other

Identification: ☐ Deaf ☐ Hard of Hearing ☐ Late Deafened ☐ DeafBlind

Consumer's communication mode:

☐ ASL ☐ PSE ☐ Signed English ☐ Tactile ☐ Oral ☐ Speech reading
☐ Sign-Supported Speech- reading ☐ Written Language:_____
☐ Comments on communication: _____

Ethnicity: ☐ White ☐ Asian/Pacific Islander ☐ Hispanic ☐ Black ☐ Unknown/Not Reported
☐ American Indian/Alaskan Native ☐ Other: _____

Briefly describe current situation

_____

_____

_____

What would you like DEAF Inc.'s Independent Living Program to address?

_____

_____

_____

Other Agencies already involved with the Consumer:

Staff Name/Agency Affiliation Phone Email

_____

_____

_____

Comment on how best to contact the consumer and if it is advisable for DEAF, Inc. to join your next meeting with the consumer. _____

_____

_____

HOW CAN WE REACH YOU?

Your Name: _____Email: _____

Relationship to person you are referring: _____

Agency: _____ TTY/Voice/VP: _____

Office: _____ Fax: _____