The Arc
Muskegon

Serving people with intellectual/developmental disabilities and their families since 1952.

Referral Form

Referral Date:_____

Person to be served

Full Name _____

Goes by _____

Phone _____ Best time to call _____AM _____PM

E-Mail_____

Preferred way of contact _____E-Mail _____Phone _____U.S. Mail

Other (please provide)_____

Age_____ Gender: _____Male _____Female

Program Service Referring to:

☐Advocacy (general help or assistance) ☐Pooled Trust Services
☐Representative Payee Services ☐Consumer Voice
☐Independent Facilitation ☐Not sure – just want to connect with The Arc

Intellectual or Developmental Disability (if known):_____

_____

____Yes, but not sure the name ____No, 'family' member in need

Person Making This Referral_____

Title_____

Contact Information_____

E-Mail_____Phone_____

Relationship (optional):
☐Professional ☐HealthWest Staff
☐Friend ☐Physician (Medical Professional)
☐Guardian ☐Attorney
☐Teacher ☐Parent/Caregiver ☐Other

Additional Details_____

_____

Signature_____Date_____

Updated December 2016