Community Support Services, Inc.
Inquiry Form

Date: _____ **Name of Person Making Referral:** _____

Relationship: _____ **Primary Language:** _____

Telephone Number: ( ) _____

Source of Referral: Family/ Friend School/ Day Program Phone Book/Web Site DD/MI Agency Governmental Agency

Other: _____

Name of Applicant: _____**Social Security #:** _____

Address: _____

City:_____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____

Name of School/School District: _____ **Special Ed Coop:** _____

County _____ **Township:** _____

Geocode: Berwyn 16/02, Cicero 16/07, Downers Grove 22/04, Leyden 16/12, Lyons 16/13,

Oak Park 16/19, Proviso 06/23, River Forest 16/25, Riverside 06/25, Stickney 16/28,

Worth 16/31

Date of Birth:_____ **Gender:** ___F ___M **Age Code:** 0-3, 4-12, 13-17, 18-22, 23-64, 65+

Disability:

_____ Autism	_____ Cerebral Palsy	_____ Epilepsy/Seizures
_____ Mental Retardation	_____ Hearing Impaired	_____ Visual Impairment
_____ Developmental Delays	_____ Spinal Bifida	_____ Communication Impairment
_____ Traumatic Head Injury	_____ Chronic Med. Cond.	_____ Prader-Willi Syndrome
_____ Fetal Alcohol Syndrome	_____ Mental Health Issues:	_____Chronic Comm Disease

_____ Other: _____

_____

Behavioral Concerns: _____

Service Needs: **Mark all programs interested in:**

Respite: _____Respite in your home ____Respite with others _____Out of home respite

Case Management: _____

Other: _____

Referred to: _____

Service Decision: _____

_____

_____

_____

Staff Name **Date**