Referral Form

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| --- | --- | --- | --- | --- |
| **IQA Case Manager** | Name: | | | Date: |
| Phone: | Email: | | |
| Best times/ways to communicate with HCBS Coordinator: | | | |
| Contact HCBS Co first?: | | 531A or 531C, 0549 form and additional personal information included with the referral: | |

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| **Consumer/Employer Information** | **Consumer Receiving Services Information** | | |
| Name: | | Prime# |
| Address: | | |
| Phone: | Email: | |
| New consumer? | | |
| Primary spoken language? | | |
| Preferred Method of Communication: | | |
| Pronoun: | | |

|  |  |
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| **Why Referring?** |  |

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| **Send Securely:** | Check this website for the consultant in the consumer’s area: <https://www.oregon.gov/dhs/SENIORS-DISABILITIES/HCC/Pages/SSPS-Workers-Contacts.aspx> or send to [OHCC.ERC@dhsoha.state.or.us](mailto:OHCC.ERC@dhsoha.state.or.us) |