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 |