



Cross Disabilities Services, Inc. P.O. Box 5070 Chapel Hill, NC 27514-5001
 Phone: (919)918-3999 Fax (919)490-2006

Referral Information Sheet

Name:	Birth date:
Sex:	SSN:
Phone#:	Medicaid#
Address:	Medicare#:
City/State/ZIP:	Language Spoken:
Are you a Citizen of the US? Y/N	Marital Status:
Guardianship status:	Name of Guardian:
Family Contact Name:	Relationship:

Treatment History

What services/assistance do you need at this time?

What services do you have or have you had before?

Have you been hospitalized within the last 2 years? If so, where and for how long?

What Medicines do you take now? What are they for?

Insurance Information

Do you currently have Medicaid/Medicare/Private Insurance? If yes please include the number.
If you do not have Medicaid, have you already applied? What is the status of your application?

Legal History

Is there any current legal involvement? (i.e. current charges, probation, parole, CRC? If yes, please explain:
Are there any past legal charges? If yes please explain:

Special Needs

Are there any issues that limit your ability to access services?
If yes, do you need any special accommodations? (i.e. TTY, interpreter services, etc)
Explain:

Name of person Completing the Form:	
Contact Phone Number:	
Contact email:	