



**Adult Services  
Request for Services  
Pre-Screening Referral Form**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: Street: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Diagnosis/Disability: \_\_\_\_\_

Was diagnosis prior to the age of 22? \_\_\_\_\_ Yes \_\_\_\_\_ No

Social Security Number: \_\_\_\_\_

Type of services requested from ICA:

Assessment: \_\_\_\_\_ Pasta Fare: \_\_\_\_\_ Off-site Employment: \_\_\_\_\_

Did individual requesting services complete a school program? \_\_\_\_\_ Yes  
\_\_\_\_\_ No

LEA: \_\_\_\_\_

Date of completion/graduation: \_\_\_\_\_

Is the individual currently receiving other services or did in the past? \_\_\_\_\_ Yes \_\_\_\_\_ No

Agency: \_\_\_\_\_

Date(s) attended: \_\_\_\_\_

Reason for leaving: \_\_\_\_\_

Is the individual registered for PUNS? \_\_\_\_\_ Yes \_\_\_\_\_ No

Is the individual Medicaid Waiver eligible? \_\_\_\_\_ Yes \_\_\_\_\_ No

Medicaid Number: \_\_\_\_\_

Does the individual receive:

Home Base Support Services funding? \_\_\_\_\_ Yes \_\_\_\_\_ No

State of Illinois or Federal Funding? \_\_\_\_\_ Yes \_\_\_\_\_ No

Is Individual own guardian? \_\_\_\_\_ Yes \_\_\_\_\_ No

If No, Guardian Name: \_\_\_\_\_ email: \_\_\_\_\_

Waiting list requisition made by/Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

Placed on vocational services waiting list: \_\_\_\_\_ Yes \_\_\_\_\_ No

If no, why? \_\_\_\_\_

ICA staff member completing request for services: \_\_\_\_\_