Referral Form – Community Connector Service (ASD Grant)

Date of referral: __________ Person making referral: ____________________

Information:

Individual's Name:	**Date of Birth:**
Parent or Guardian Name(s):	
Address:	
Phone:	**Email:**
Case Manager (if applicable):	

Eligibility:

- Must have a diagnosis of an Autism Spectrum Disorder or related condition (please attach supporting documentation to referral form)
- Must reside in either Dakota or Ramsey County
- Not available to individuals living in Corporate Foster Care

Individual's diagnosis or disability:

Describe any medical concerns or needs:

Current financial services/resources (ex: TEFRA, CADI, CDCS, Private Insurance):

Please list all current services utilized (ex: case management, PCA, ILS, CTSS):

History of services utilized:

Are there significant behavioral issues disrupting family life? Yes ☐ or No ☐

If yes, describe:

Are there factors that are increasing stress in the family? (Ex. Single parent, family size, loss of job, other family members with disabilities, low income):

Current informal supports (ex: unlicensed persons, family, friends, and neighbors):

Goals for service (ex: make new friends, build family support, join social club, etc.):

Completed forms should be submitted to Evan Henspeter
Email: Evan.Henspeter@co.dakota.mn.us