State of Illinois
Department of Human Services

SUPPORT SERVICES TEAMS REFERRAL FORM

SST Receiving Referral | **County of Person's Residence** | **Date of Referral** | **Time of Referral**

Last Name of Person Referred | **First Name of Person Referred** | **Birthdate** | **Age** | ☐ Female ☐ Male

Social Security Number | **RIN** | **Medicare Number, if known** | **Type of Living Arrangement**

Address of Current Residence | **How long at this residence, if known**

Where is the Person Right Now? | **Person's Communication Method** | **Provider FEIN**

Provider Name | **Provider Address**

Executive Director Name | **Executive Director Phone Number** | **Executive Director Email Address**

Provider Contact Name | **Provider Contact Phone Number** | **Provider Contact Email Address**

PAS/ISC/ISSA Agency Name | **PAS/ISC/ISSA Contact Name** | **Contact Phone Number**

Guardianship Status | **Guardian Name & Contact Information**

Name and Contact information of Family Contact (if different from the Guardian listed above)

Referring DDD Staff Name | **DDD Bureau** | **Specific DDD Unit Assignment** | **DDD Staff Phone Number**

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Reason for Referral	Frequency	Severity
Reason for Referral	Frequency	Severity
Reason for Referral	Frequency	Severity
Reason for Referral	Frequency	Severity

Insert a brief narrative describing the person being referred and the reasons for referral: