UNIVERSAL REFERRAL FORM

DIL, inc.

Bio-Data/General Information			
Consumer Name:		Date of birth:	
In your own words, what is your gender ID:		Diagnosis (if applicable):	
CIN#:		Social Security #:	
Address:			
City:	County:	State:	Zip:
Phone:		Email:	
Best time to call:			

Reasons for Referral *(explain reasons for referring the case with any supporting notes if available. Use additional pages if necessary)*

Program(s) Needed	
☐ HHUNY	☐ Youth/S.E.
☐ CHHUNY	☐ NOEP
☐ ABD(Facilitated Enroller)	☐ Dwyer Veterans
☐ Transitions	☐ Transportation
☐ COMHAB	☐ Rep-Payee
☐ COMPEER	☐ Non-Medicaid
☐ NY Connects	☐ SSI
☐ STRAWW	☐ Other
Has consumer received services from DIL before? Yes___ No___	
Is this person receiving any other supporting services? Yes___ No___	
If so, from what agency?	
Any safety concerns for consumer?	
Any safety concerns for assigned staff?	
Is this an emergency? Yes___ No___	
Any other important information?	

Person Referring:	Date Referred:
Phone:	Email: