Community Connect Referral From

Please send the referral to adrc@waukeshacounty.gov or fax to (262) 896-8273

Date _____

Name of person referring _____ Agency Name _____

Agency Phone # _____ Agency Fax # _____

Email _____

Client Information

Name _____ DOB _____

Apartment Complex Name _____

Address _____ Apt # _____

City _____ State _____ Zip Code _____

Primary Phone Number _____ Email:_____

Please make contact with (include name/phone/relation): _____

Follow Up Requested From ADRC For (check all that apply):

- ☐ Adult Day Care
- ☐ In-Home Services
- ☐ Respite
- ☐ Meal Assistance
- ☐ Transportation
- ☐ Other _____
- ☐ Long Term Care Program Eligibility
- ☐ Caregiver Support/Services
- ☐ General Concerns about Client
- ☐ Options Counseling
- ☐ Housing

Is client and/or the contact person aware of referral to the ADRC? ☐ Yes ☐ No
If no, please explain why not. _____

Was an in-home assessment completed by your agency? ☐ Yes ☐ No

Are there any home safety concerns or consumers behaviors that we should be aware of? ☐ Yes ☐ No
If yes, please explain. _____

Notes about client (Please share the reason for the referral, any details about the consumer, any details about the home, what services are you providing for this client, etc.) _____