

**Independent Living Choices Participant Referral Form**

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| Participant Name: |  |
| DOB: |  |
| Phone Number/ Contact Person: |  |
| Address: |  |
| Is this person a Veteran? |  |
| Does the person receive SSI, SSDI? |  |
| Does the person utilize a South Dakota Waiver Program? (FS360, CHOICES, ADLS, etc.) |  |
| Disability/Diagnosis: |  |
| Service(s) needed: |  |
| Notes: |  |