Referral for Services and Supports

the PIONEER CENTER
Ross County Board of DD

Referral Date:_____ Referral Taken By:_____

Name of Individual: _____

Address:_____ Phone: _____

Date of Birth:_____ Age:_____ Sex:_____

Social Security Number: _____ Medicaid Number: _____

Referral Source Name:_____ Relationship/Agency: _____

Referral Source's Contact Information: _____

Additional Contact Person(s):_____ Relationship: _____

Contact Person's Contact Information: _____

Has the individual ever received DD services before? ☐YES ☐NO Previous County Board: _____

Details: _____

_____

Desired Services: _____

_____

Where to Obtain DD Diagnosis: _____

_____

Additional Information: _____

_____

_____

_____

_____

***Submit Referral Forms to: 167 W. Main Street Chillicothe, Ohio 45601 or fax (740) 775.7236*