MDRS | MISSISSIPPI DEPARTMENT OF REHABILITATION SERVICES
Opportunities for Independence

Office of Special Disability Programs
Referral Form

Social Security # : | **Referral Name:**

Date of Birth: | **Date of Referral:**

Street Address: | **County:** -Select-

Mailing Address:

Primary Phone:( ) | **Secondary Phone:( )**

Disability/Diagnosis:
(Must be specific.)

ADL Deficits: (Check all that apply.) ☐ **Eating** ☐ **Toileting** ☐ **Bathing**

☐ **Dressing** ☐ **Ambulation** ☐ **Transferring** ☐ **Personal Hygiene**

Referral Source: | **Contact Phone: ( )**

Responsible Relative: | **Contact Phone: ( )**

Physician Name: | **Physician Phone: ( )**

Physician Mailing Address:

Services Requested: (Check all that apply.) ☐ **Attendant Care** ☐ **Transition Services**

☐ **Respite Services** ☐ **Supplies*** _____

☐ **Vehicle Modifications** _____

☐ **Aids/Equipment*** _____

☐ **Environmental Accessibility Adaptions (Home Modifications)**

_____

***For Medicaid, Medicare, and Private Insurance recipients, please verify that equipment/supplies are NOT covered by a third party <u>prior</u> to entering a referral. These items include, but are not limited to: hospital beds, wheelchairs, and hydraulic lifts.**

Current Equipment:
(Age and Source)

Medicaid # | **Medicare #** | **Private Insurance #**

Income: Social Security $_____ SSI $_____ SSDI $_____ Other $ _____

Did you remember to check Envision? ☐ **Yes** ☐ **No**

What other public assistance is already provided? _____

Email your completed form to: OSDPReferral@mdrs.ms.gov

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