Real Life Living Services
PO BOX 3915
ANN ARBOR MI 48106-3915
North Michigan Office
140 W. RIVER ST. #5
CADILLAC MI 49601-1284

New Client Services Referral Form

Please send all new referrals to nwm@rlls.org to ensure the proper team receives them.

Client Information ***DOB:*** _____ Gender: Select Option

First Name: _____ Last Name: _____

Client EHR/EVV Medicaid ID #: _____ Phone Number: _____

Address: _____ City: _____ Zip Code: _____ Apt #: _____

Guardian: NA If so, name: _____ Phone #: _____

Services Information ***Responsible Payer for Services:*** _____

Hours/Units authorized for service: _____ Per: Select Option
(Please identify hours or units)

Types of Services : Select Option CPT billing Code: _____ Start Date: _____

Is consumer willing to only have a certain number of days per week? NA

Preferred days/times of service delivery: _____

Or is Consumer OK with getting less if they only want to work with one staff? NA

Will Staff Dispense Medication to Client? No

Is reminding, monitoring, and/or observation of medication administration needed? NA

Home Environment

Smoking: NA Dogs: NA Cats: NA Other Pets: _____ Siblings: NA

IPOS Goals (please list) ***Date of most recent IPOS:*** _____

Please attach the IPOS, Authorization, and any other needed info (IE. Psychosocial Assessment)

Additional Information

Medical needs: _____

Communication Plan: _____

Behavioral Plan: NA

Comments: _____

History of Behaviors:

Please select one that in the dropdown options or add "other" in the comments above

Supports Coordinator Name: _____ Phone #: _____
Email: _____