Capital District Center for Independence, Inc.

Consumer Referral Form

Date: ______________

Name: ____ Date of Birth: ___________________

Address: ____

City: ___________________________ State: ___________________ Zip Code: ________________

County: ______________________________ Phone Number: _____________________________

Email: ____

☐ *I do not wish to receive emails from CDCI.*

Gender: ☐Male ☐Female ☐Other Preferred Pronouns: ___________________

Which of the following best describes your race.

☐American Indian or Alaska Native
☐Asian
☐Black or African American
☐Native Hawaiian or Pacific Islander
☐White, Caucasian
☐Hispanic/Latinx only
☐Two or more races

What is your ethnicity?

☐Hispanic/Latinx
☐Non-Hispanic/Latinx

I am a…

☐ Person with a disability ☐ Family/Friend ☐ Professional

What category best describes your disability? *Check all which apply.*

Multiple Disabilities? ☐Yes ☐No

Cognitive	**Physical**	**Mental**	**Sensory**
☐Intellectual/Development	☐Spinal Cord Injury	☐Mental Illness	☐Blindness
☐Traumatic or other brain injuries	☐Spina Bifida	☐Substance Abuse	☐Deafness
☐Autism	☐Neuromuscular	☐Emotional/ Behavioral	☐Deaf/Blind
☐Learning Disability	☐Orthopedic	☐ADHD	☐Low Vision
☐Other	☐Cerebral Palsy	☐Other	☐Hard of Hearing
	☐Epilepsy		☐Other
	☐Muscular Dystrophy		
	☐Amputation		
	☐Back Injury		
	☐HIV/AIDS		
	☐Environmental		
	☐Other physical		
	☐Other congenital birth anomaly		

Have you worked with CDCI before? ☐ **Yes – When (*year*)? ____________** ☐ **No**

Who referred you to our services?

Name ______________________ Relationship ______________________

Organization *(if applicable)* ______________________

Phone ______________________ Email ______________________

Please tell us which services you are seeking.
Check all which apply.

☐Advocacy/Legal Services
☐Architectural Barrier Services
☐Assistive Technology
☐Benefits Advisement
☐Children's Services
☐Communication Services
☐Counseling and Related Services
☐Employment Services
☐Family Services
☐Housing, Home Modifications, and Shelter
☐IL Skills Training and Life Skill Training Services
☐Information and Referral
☐Mobility Training Services
☐Peer Counseling Services
☐Personal Assistance
☐Physical Restoration Services
☐Preventive Services
☐Prostheses, Orthotics, and Other Appliances
☐Plan to Achieve Self-Support
☐Recreational Services
☐Rehabilitation Technology Services
☐Therapeutic Treatment
☐Transportation Services
☐Youth/Transition Services
☐Vocational Services
☐Voter Registration

☐Other ______________________

COVID-19 and NYS PAUSE

Have you been affected by COVID and NYS PAUSE? ☐ Yes ☐ No
Do you require assistance? ☐ Yes ☐ No

In which areas do you need assistance?
Check all which apply.

☐COVID-Related Benefits
☐Employment Assistance
☐Communication Assistance
☐Food Insecurity
☐Housing Insecurity
☐Independent Living Skills
☐Safety Information
☐Socialization Assistance
☐Wellness Assistance

☐Other ______________________