



# YUKON-KUSKOKWIM HEALTH CORPORATION

## Developmental Disabilities Referral Form

Yukon Kuskokwim Health Corporation  
Developmental Disabilities Program  
P.O. Box 528 • Bethel, AK 99559

**Phone:** 907-543-2762 ext. 1768  
**Toll Free:** 1-800-478-3321, ext. 1768  
**Fax:** 907-543-2796

Person being referred: \_\_\_\_\_ Date: \_\_\_\_\_  
*(Last name, First name, Middle Initial)*

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Medicaid #: \_\_\_\_\_

Parent/Guardian Name and Address: \_\_\_\_\_  
\_\_\_\_\_

*Some categories of disabilities that qualify a person to receive services through the Developmental Disabilities Program include: mental retardation, autism, cerebral palsy, seizures and other acute or chronic medical conditions of three month duration. This determination will be confirmed once a person is referred and voluntarily consents to participate in this program.*

Person making referral and address/phone: \_\_\_\_\_  
\_\_\_\_\_

Reason for referral: What category do you suspect may qualify this person for this program?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What kind of services is this client requesting? \_\_\_\_\_  
\_\_\_\_\_

Do you know of any health professionals who have examined this person? (Please list) \_\_\_\_\_  
\_\_\_\_\_

Please list any other agencies that may have appropriate information on this person: \_\_\_\_\_  
\_\_\_\_\_

Would you be willing to help us in our follow-up on this referral?  Yes  No

*Please return form to address at the top of page. Thank you.*