

### Self-Directed Services Referral Guide

Person Supported: _____ Date: _____	
Address: _____ County: _____	
Phone: _____	Email Address: _____
DOB: _____	Gender: _____
Medicaid #: _____	Tab ID # _____ Social Security # _____
Representative: _____ Relationship to Person: _____	
Phone: _____ Email Address: _____	
<b>Required Documentation:</b> (Mark Included Items) <input type="checkbox"/> Active NOD <input type="checkbox"/> Current Published Life Plan <input type="checkbox"/> Authorization for Self-Directed <input type="checkbox"/> Most recent DDP2 with scores	Attended a Self-Direction Information Session? YES <input type="checkbox"/> / NO <input type="checkbox"/> Date of Attendance: _____
<b>Referral for Fiscal Intermediary?</b> YES / NO <input type="checkbox"/> / <input type="checkbox"/>	
Identified Broker: _____ Phone: _____ Email: _____	
<b>Referral for Broker Services?</b> YES / NO <input type="checkbox"/> / <input type="checkbox"/>	
Identified Fiscal Intermediary: _____ Phone: _____ Email: _____	
<b>Is this person new to Self-Directed Services or transferring services?</b> _____ If transfer, name of current provider: _____ Phone: _____ Email: _____	

Care Coordinator Printed Name: \_\_\_\_\_ Email: \_\_\_\_\_

Care Coordinator Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Care Coordinator Signature: \_\_\_\_\_ Date of signature: \_\_\_\_\_

**Referrals to be submitted to:**

**Western NY- Judy Peck**  
Director of Innovative Services  
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**Finger Lakes Area-Jonathan Stromsness**  
Associate Director of Self-Directed  
Services  
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