BEACON Specialized Living
KEYSTONE COMMUNITY RESOURCES

Please send referral back to aholmes@keycommres.com

If you have any questions Please contact Paige Della Camera our admissions coordinator at *aholmes@keycommres.com or 570-702-8048.*

CONFIDENTIAL

Persons completing this document and the persons receiving the disclosed information may only further disclose consistent with the authorized purpose for which it is intended or disclosed (MH 1748-[3]).

Please answer the following questions related to the consumer:

Referral Name:		**DOB:**		**Age:**	
		Sex:			
County of Funding:		**Approved Funding Source:**			
Referred by:		**Contact information:**			
Services:	☐**Residential** ☐**Behavioral Support** ☐**Community Participation Supports** ☐**Life Sharing / Family Living** ☐**Employment Supports** ☐**Supporters Broker** ☐**In-home and Community/ Campion** ☐**Supports Coordination- NJ ONLY** ☐**Other: _____**				
Desired Service Location:					
Reason for Referral:					

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Guardianship Status:	☐**Self** ☐**Other:** **Guardian Name and relationship**
Representative Payee	☐**Self** ☐**Other:** **Guardian Name and relationship**

Diagnosis:

Diet:

Allergies:

Medications: (current medications. Please list below or attach a list)

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Referral Packet – PA and NJ Programs

Medical Summary:

Past Hospitalization (medical and Psychiatric):

Psychiatric Presentation:

Please attach the following required documents if available:

- Current Individual Support Plan (for all Services)
- Current SIS Assessment
- Guardianship Paperwork
- Current Psychiatric Evaluation
- Any Psychological Assessments
- Life Time Medical information
- Current Physical/Immunization Record
- Upcoming Medical/Dental Appointments
- Current Medication List/Current Prescriptions
- Behavior Plan, if applicable

Thank you for your referral!
We look forward to serving you, the individual and the community.