SERVICES FOR INDEPENDENT LIVING

INCLUSION | INTEGRITY | INNOVATION

Individuals' Name: _____ Date of Referral: _____

Individuals' Date Birth: _____

If individual is not their own guardian or has POA, please attach the legal information.

Individual's Address: _____

City: _____ State: Ohio Zip: _____

County: ❑ Cuyahoga ❑ Lake ❑ Geauga

Phone Number(s): _____ _____

I identify with the following disability/disabilities:

_____

_____

SIL services are listed below. Please place a check mark next to the program you are interested in and PLEASE EXPLAIN specifically the areas you feel you require assistance and support with the most, as it relates to the requested service.

All topics are highly individualized and may include, but are not limited to: budgeting, safety in the community, maintaining a household, preparing meals, increasing self-advocacy skills, accessing the community and preparing for an emergency.

❑ **YouthAbilities:** Focuses on youth between the ages of 14-22. Helps youth gain skills needed to transition into the adult world of work, post-secondary education and community living.

Specifics I need to work on: _____

_____

_____

❑**Independent Living Skills and Evaluation:** Helps individuals gain skills needed to maintain an independent lifestyle. An evaluation can be requested to assess the individual's baseline abilities for areas of potential growth, related to living an independent lifestyle.

Specifics I need to work on: _____

_____

❑ **Peer Support:** SIL staff help individuals with disabilities identify appropriate ways to manage challenges related to gaining and maintaining independence at home and in their community of choice.
Specifics I am looking to gain assistance with:_____
_____
_____

The following programs require an additional application process:

❑ **Young Adult Council:** A program designed to allow young adults with disabilities to form their own community led council; hands-on/internship approach that will give young adults the opportunity to participate in a realistic policymaking environment; they will learn to make decisions, solve problems, and promote systems change on all levels.
_____
_____
_____

Will you need any accommodations (interpreter/CART) to participate in services? ❑ Yes ❑ No
If yes, please describe: _____

I, _____, acknowledge that I am being referred to Services for Independent Living for services to enhance my independence. My signature reflects that I agree to the information provided on this referral.

Signature:_____

(Signature of the PERSON BEING REFERRED is REQUIRED for any/all services – SIL does not accept "verbal consent" or a signature from anyone other than the referred).

Referring agency and/or person_____

Name of person completing form(if not self): _____

Phone Number: _____ Email: _____

If you have any questions, please call Shannon Monyak at (216) 731-1529. Please return form to Shannon by fax at (216) 731-3083 or by E-mail at smonyak@sil-oh.org