VERIFICATION OF REFERRAL

Date of Referral: _____

AIP/IP: _____ AIP Birth Date: _____
(Legal Name and known Aliases)

AIP SSN: _____ Court CAUS Number: _____

Referred by: _____
(Name, Title / Agency / Phone / e-mail)

The AIP/IP referred *(check all that apply):*

☐ Resides in Washington State (*please indicate which county):*

☐ Clallam ☐ Grays Harbor ☐ King ☐ Okanogan
☐ Pierce ☐ Snohomish ☐ Spokane

☐ Is age 18 years or older.

*Verification Document/Method _____

☐ Income does not exceed 200 percent of the federal poverty level. *For 2011, income cannot exceed $21,780.00 annually or $1,815.00 monthly; this number may change from calendar year to calendar year and the eligibility would change accordingly.*

*Verification Document/Method _____

☐ Is receiving long-term care services through the Washington State Department of Social and Health Services

*Verification Document/Method _____

☐ There is no one else qualified, willing and able to serve.

*Verification Document/Method _____

****** Please verify that you have determined that no family or friends are willing and able to serve.***

PRIORITIES *(check all that apply):*

☐ Indigent/Homeless

☐ At significant risk of harm from abuse, exploitation, abandonment, neglect, or self-neglect.

☐ In imminent danger of loss or significant reduction in public services that are necessary to live successfully in the most integrated and least restrictive environment that is appropriate for a specific individual.

****** Please indicate how you determined that the particular eligibility requirement was met.***

WASHINGTON STATE ADMINISTRATIVE OFFICE OF THE COURTS
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