iLIFE
Choice. With Confidence.

CLTS

Referral Form

Children's Long-Term Waiver Respite Care

Please complete and email to FISCAL@iLIFE.org

Date: / /

Coordinator: _____

Email: _____

☐ New ☐ Re-referral

EMPLOYER/CLIENT

Child Name:		DOB: / /
Race:		Gender:
Address:		City:
County:	State: WI	Zip code:

PARENT/GUARDIAN

Name(s):	Relationship:
Primary Phone:	Secondary Phone:
Primary Email:	Secondary Email:

AUTHORIZED SERVICES

Provider	Authorized Service	Rates	Hours
Name: _____ Contact Info: _____		Provider $ _____ /hr Billable $ _____ /hr	_____ Hours per ☐ Week ☐ Month ☐ Check if shared between workers ☐ Check if flexible monthly usage
Name: _____ Contact Info: _____		Provider $ _____ /hr Billable $ _____ /hr	_____ Hours per ☐ Week ☐ Month ☐ Check if shared between workers ☐ Check if flexible monthly usage
Name: _____ Contact Info: _____		Provider $ _____ /hr Billable $ _____ /hr	_____ Hours per ☐ Week ☐ Month ☐ Check if shared between workers ☐ Check if flexible monthly usage
Name: _____ Contact Info: _____		Provider $ _____ /hr Billable $ _____ /hr	_____ Hours per ☐ Week ☐ Month ☐ Check if shared between workers ☐ Check if flexible monthly usage

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