OUR SPACE INC
A community that cares and grows together
1527 W. National Ave Milwaukee, WI 53204 P-414-383-8921 F-414-383-9016

Comprehensive Community Services Referral for Ancillary Services

County Requesting Services: ☐ Rock Co ☐ Walworth Co ☐ Jefferson Co

Referral Date: _____ Agency: _____

Referred by: _____Phone: _____
Name of Case Manager/Care Coordinator

Name of Individual being Referred: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____ Availability: _____

Diagnosis/Disability/Drug of Choice: _____

Personal Pronouns: _____ Allergies: _____

1. **Service Category: _____Service Code _____**
   - **Specific tasks being requested: _____**
   - **Goal of this task:_____**
     _____
2. **Service Category: _____Service Code _____**
   - **Specific tasks being requested:_____**
   - **Goal of this task:_____**
     _____
3. **Service Category: _____Service Code _____**
   - **Specific tasks being requested:_____**
   - **Goal of this task:_____**
     _____

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Appointment days/times that work best for the consumer:_____

Gender Preference of Provider: ☐**Male** ☐ **Female**

Cultural Preference of Provider:

☐ **White** ☐ **Black or African American** ☐ **American Indian or Alaska Native** ☐**Asian** ☐ **Native Hawaiian or Other Pacific Islander** ☐**Other:**_____ ☐**Hispanic**

Currently Taking Medications? ☐ **Yes** ☐ **No** **If so, please list medications?**

_____

_____

Special Accommodation Needs, if any *(i.e., physical limitations, medical concerns, communication needs (language) location of service, etc):* _____

_____

Strengths/Interests*:* _____

If in-home services are provided, will anyone else be present in the household during contacts? ☐ **Yes** ☐ **No**

If you answered yes, who will be present? _____

Environmental Safety Concerns (large animals, unsafe neighborhood, etc.): _____

_____

Telehealth Service Delivery (Peer Support): Peer Support will be delivered through telehealth (video/phone) with participant's informed consent. Participant acknowledges understanding of telehealth delivery, agrees to participate, and will confirm location and emergency contact information at each session to ensure safety.

Telehealth Service Delivery (Peer Support):

- ☐ **Video (HIPAA-compliant platform)**
- ☐ **Phone (if video unavailable)**
- **Participant consent obtained for telehealth**
- **Participant location confirmed at each session**
- **Emergency contact on file**
- **Technology access reviewed; barriers noted if present**

Please submit completed referrals to Melissa Wisniewski at mwisniewski@ourspaceinc.org and nhitchcock@ourspaceinc.org. For questions or concerns, contact Melissa at (414) 877-5911.