PIONEER RESOURCES
Opening Doors of Opportunity

Referral Date: _____

PARTICIPANT INFORMATION

Full Name: _____
First Middle Initial Last

Preferred Name: _____ Date of Birth: ____/____/____
MM DD YYYY

Gender Identity: ☐Male ☐Female ☐Non-binary/Undisclosed

Cell Phone: _____ Home Phone: _____

Email: _____ County: _____

Address: _____
Street City State Zip Code

Ethnicity: ☐White/Caucasian ☐Black/African American ☐Hispanic or Latino
☐Asian ☐American Indian ☐Alaskan Native
☐Native Hawaiian ☐Pacific Islander ☐Other (Biracial)
☐Prefer not to disclose

Marital Status: ☐Single ☐Divorced/Separated ☐Married: _____
Spouse's Name

Education: _____ ☐Current Student ☐Not a Current Student
Name of School Currently or Last Attended

Current Employer: _____

Disability: ☐Cognitive Impairment/Developmental Disability ☐Physical Disability
☐MI ☐Autism ☐Dually Diagnosed ☐Other: _____

Mobility: ☐Without Assistance
☐With Physical Assistance (hands on assist with steps/uneven ground)
☐With Mechanical Assistance (mobility devices, walkers, canes, lifts)

Criminal History: Does the participant have a felony conviction? ☐No ☐Yes (explain) Date:_____
Is the participant currently on probation? ☐No ☐Yes (explain)

_____
_____
_____

Does the participant have a current: ☐Driver's License ☐State ID ☐Bus Pass
Does the participant receive: ☐TANF ☐SNAP ☐Government Assistance (Any Kind) ☐N/A
Is the participant a veteran or an immediate family member a veteran? ☐Yes ☐No

Please indicate the program for which you are referring the participant:

☐Community Connections (Group Community Living Supports [CLS)
☐Employment / Vocational Training
☐Skill Building (Vocational Track)
☐Skill Building (Group CLS)
☐Leisure and Recreation Club (LARC)
☐Supported Independent Living (Marcoux)

Does the participant need personal care assistance? ☐No ☐Yes (explain below)

_____
_____
_____

Does the participant need or request behavioral supports? ☐No ☐Yes (explain below)

_____
_____
_____

Date of the last Person Centered Plan, IEP, or other individualized plan of service: _____

Other Relevant Information: _____
_____
_____
_____

REFERRING AGENCY/ENTITY INFORMATION

Agency/Entity Name: ☐HealthWest ☐MAISD ☐MRS ☐Ottawa County CMH
☐School District: _____ ☐Other: _____

County: _____

Name of Person Making Referral: _____
First Middle Initial Last

Title: _____ Email: _____

Office Phone: _____ Cell Phone: _____

Relationship to Participant: ☐Parent/Guardian ☐Payee ☐Other: _____
☐Supports Coordinator /Case Worker

_____ _____
Signature of Referring Person Date

PLEASE SUBMIT TO PIONEER RESOURCES

Mail: ☐601 Terrace Street, Suite 100, Muskegon, MI 49440

Email/Fax: ☐ Stacy Freed Email: sfreed@pioneerresources.org
Fax: 231.220.0244