



COMPANY NAME

Address

Casual Consumer Form

Start Date: _____

Ending Date: _____

Staff: _____

Individual's Name: _____ Phone #: _____

Agency: _____ Address: _____

City: _____ State: IL Zip Code: _____

****Staff: please note that you are required to document date and time spent. All other information is not necessary for minimum reporting requirements but may be helpful at a later date.****

Date: _____ **Time Spent:** _____

Date: _____ **Time Spent:** _____

Date: _____ **Time Spent:** _____

Total Time: _____

Age Range: Under 6 6-17 18-22 23-54 55 & Over

County: Morgan Cass Scott Mason Other

Referred To JACIL By:

Self Family or Friend Media/TV/Print/Radio

Brochure/Materials JACIL Staff/Presentation

Service Provider: _____

Other: _____

JACIL Information and Referral Form Continued (Page 2)

Disability: Fill out **ONLY** if the referral has a disability **AND** if he or she is requesting information for personal needs.

- | | | | |
|------------------------------------|--|-----------------------------------|----------------------------------|
| <input type="checkbox"/> Cognitive | <input type="checkbox"/> Emotional/Mental | <input type="checkbox"/> Physical | <input type="checkbox"/> Hearing |
| <input type="checkbox"/> Vision | <input type="checkbox"/> Multiple Disability | | |

Information/Assistance Provided:

- | | |
|--|--|
| <input type="checkbox"/> Advocacy/Legal | <input type="checkbox"/> Peer Counseling |
| <input type="checkbox"/> Children (6 and under) | <input type="checkbox"/> Personal Assistance |
| <input type="checkbox"/> Communication | <input type="checkbox"/> Prevention |
| <input type="checkbox"/> Counseling and Related Services | <input type="checkbox"/> Recreational |
| <input type="checkbox"/> Family | <input type="checkbox"/> Rehabilitation Technology |
| <input type="checkbox"/> Housing, Home Modifications & Shelter | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Independent Living & Life Skills Training | <input type="checkbox"/> Vocational |
| <input type="checkbox"/> Information & Referral | <input type="checkbox"/> Youth (Ages 14-24) |
| <input type="checkbox"/> Mobility Training | <input type="checkbox"/> Other |

Explanation of Other: _____

NOTES/COMMENTS: