Independent Living Services Referral Form

Deaf and Hard of Hearing Independent Living Services
Referral Line: (413) 650-5365 • FAX: (413) 493-3969
DHILS@viability.org

Date of Referral: ___/___/_____

Referred by: ___________________________ Agency/Role: _______________________

Phone: _______________________ Email: __________________________________

Person being referred: ____
First MI Last

Address ____

City: _______________________________ State: ___________ Zip Code: _______

Gender: Female ☐ Male ☐ Transgender ☐ Other ☐ DOB: _________________

Phone: ____________________ VP/Voice/TTY Email: ____________________________

Identity: Deaf ☐ Hard of Hearing ☐ Late Deafened ☐ Oral Deaf ☐ Deaf-Blind ☐

Communication Preference(s): ASL ☐ Spoken English ☐ Tactile ☐ Other____________

Have Mass Health? Yes ☐ No ☐

Service(s) Requested:

☐ Transition to Adulthood Services

☐ Skills Training ______________

☐ Financial/Benefits Assistance

☐ Housing

☐ Budget training

☐ Assistive Techology/Equipment

☐ Information & Referral

☐ Advocacy

☐ Communication Skills

☐ Health Care/Nutrition

☐ Other ____
(Please specify)

Additional Comments: