PIONEER RESOURCES
Opening Doors of Opportunity

Participant / Resident Information

Referral Date: _____

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

_____
_____
_____
_____

Does the participant/resident have a current: ☐Driver's License ☐State ID ☐Bus Pass

Please indicate the program for which you are referring the person served:

☐Group Community Living Supports (CLS)
☐Employment / Vocational Training
☐Pre-ETS (Pre-employment transition services)
☐Skill Building (Vocational Track)
☐Skill Building (Group CLS)
☐Leisure and Recreation Club (LARC)
☐Specialized Housing
☐Supported Independent Living

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

_____

_____

_____

Does the person served 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 ☐BSBP ☐Ottawa County CMH

☐School District: _____ ☐Other: _____

County: _____

Name of Person Making Referral: _____
First Middle Initial Last

Title: _____ Email: _____

Office Phone: _____ Cell Phone: _____

Relationship to Person Served: ☐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: programs@pioneerresources.org
Fax: 231.220.0244