DEAF, Inc.'s Project HOPE

REFERRAL FOR SERVICES

Fax: 617-254-7091

INFORMATION ABOUT THE CONSUMER YOU ARE REFERRING:

Name: _____
Last First Middle

Street Address: _____

Town: _____ State: _____ Zip: _____

Phone Number: _____ Voice/TTY/Both/VP

Email/Pager: _____

Social Security No.: _____ - _____ - _____ Date of Birth: _____

Gender: ____Male ____Female

Hearing Status: ____ Deaf ____Hard of Hearing ____Late-Deafened ____Deaf-Blind

Ethnicity:
____ White ____Asian/Pacific Islander ____ Hispanic
____ Black ____ American Indian/Alaskan Native ____ Other
____ Unknown/Not Reported

Comment on medical or health issues you would like DEAF, Inc.'s Project HOPE to address:

Other Agencies already involved with the Consumer:

Name/Agency Affiliation Phone

Comment on how best to contact the consumer, including if it is advisable to meet with you at your next meeting:

How can we reach you: **Name:** _____

Address: _____

Phone Number: _____

FAX Number: _____