****

**START Screening & Referral**

| Individual’s Name: |  | DOB: |  |
| --- | --- | --- | --- |
| Gender: | ☐ Male ☐ Female ☐ Self-Describe: |
| Legal Guardian? | ☐ Yes ☐ No | Lives with Guardian: | ☐ Yes ☐ No |
| Address |  | County: |  |
| City/State |  | Zip |  |
| Medicaid Number  |  |  |  |

For children under the age of 18:

| Who child lives with: |  | Custody Status: |  |
| --- | --- | --- | --- |

**Demographics**

| **Race** | **Ethnicity** | **Primary Language** |
| --- | --- | --- |
| ☐ African American/Black☐ American Indian/Alaskan☐ Asian☐ Hawaiian/Pacific Islander☐ White☐ Other: | ☐ Hispanic☐ Non-Hispanic☐ Unknown | ☐ English☐ Spanish☐ Sign Language☐ Other:  |

**Living Situation**

☐ HCBS Group home

☐ Assisted Living Facility

☐ Intermediate Care Facility (ICF)

☐ Family home

☐ Foster care home

☐ Group home

☐ Homeless, sheltered

☐ Homeless, unsheltered

☐ Independent living (no SCL supports)

☐ Jail

☐ Psychiatric hospital

☐ State operated I/DD center

☐ Supervised apartment

☐ Supported living (own home w/hourly SCL)

☐ Residential Care Facility (RCF)

☐ Other:

**Referral Information**

| Referred by: |  | Agency if applicable |  |
| --- | --- | --- | --- |
| Email Address: |  | Phone: |  |

**Referral Source**

☐ Case Manager/Service Coordinator

☐ Community psychiatric inpatient

☐ Day/Vocational service provider – community

☐ Emergency services/Mobile crisis team

☐ Family member

☐ Friend

☐ Hospital emergency department

☐ Law enforcement

☐ Legal advocate

☐ Legal Guardian (non-familial)

☐ Mental health professional

☐ Mobile Crisis

☐ Residential provider - Community

☐ School

☐ Self

☐ State operated I/DD center

☐ State psychiatric hospital

☐ Other

**Presenting Problems at Referral (check all that apply)**

☐ Aggression (physical, verbal, property destruction, threats)

☐ At risk of losing placement

☐ Decrease in ability to participate in daily functions

☐ Diagnosis and treatment plan assistance

☐ Family needs assistance

☐ Leaving unexpectedly

☐ Mental health symptoms

☐ Self-injurious

☐ Sexualized Behavior

☐ Suicidal ideation/behavior

☐ Transition from hospital

☐ Other:

Reason for referral/presenting problem: Include recent changes in social functioning, health, level of engagement, etc. How long has this been happening?

|  |
| --- |

Describe the onset of the problems/concerns: What services/supports are you looking for by making this referral?

|  |
| --- |

**Caregiver Information**

**Primary Caregiver**

☐ Parent

☐ Other Family Member

☐ Paid Support Staff

☐ Self

☐ Guardian/Authorized Representative

☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

| Name: |  | Relationship: |  |
| --- | --- | --- | --- |
| Email: |  | Phone**:** |  |
| Address: |  |
| **Speak with Guardian?**  | ☐ Yes / ☐ No  **Left a message at (date/time): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**Does the individual have a secondary caregiver?** ☐ Yes / ☐No(if yes, indicate type of caregiver)

☐ Parent

☐ Other Family Member

☐ Paid Support Staff

☐ Guardian/Authorized Representative

☐ Self

☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Diagnostic Information**

**Level of ID**

☐ Normal intelligence

☐ Borderline

☐ Mild

☐ Moderate

☐ Severe

☐ Profound

☐ None noted

**DSM 5 Diagnosis**

| Psychiatric Diagnosis: |  |
| --- | --- |
| IDD Diagnosis: |  |
| Medical/Health Conditions: |  |
| Social Stressors: |  |

**Documentation & Disposition**

**Team Contact Information**

| Name: | Role: | Email: | Phone: |
| --- | --- | --- | --- |
|  | Family |  |  |
|  | Guardian |  |  |
|  | Residential Provider  |  |  |
|  | Day/Vocational  |  |  |
|  | Case Manager  |  |  |
|  |  |  |  |
|  |  |  |  |

**Funding Source (check all that apply)**

☐ ID Waiver ☐ Medicaid ☐ None

☐ BI Waiver ☐ Medicare ☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ Habilitation ☐ Private Insurance

**Thank you!**

We look forward to collaborating with you!

The *I-START* Team

**\*\*Internal use only\*\*\***

**Documentation Checklist**

| Required Documentation | Date received |
| --- | --- |
| Psychological evaluation with FSIQ ☐ Yes ☐ No |  |
| Adaptive Functioning Assessment ☐ Yes ☐ No |  |
| Other Documentation (list) |  |
|  |  |
|  |  |
|  |  |
|  |  |

**Suitability of enrollment in START:**

☐ Appropriate ☐ Inappropriate Reason:

**Disposition:**

☐ Accepted for START Enrollment

| Coordinator Assigned |  | Date: |  |
| --- | --- | --- | --- |

☐ Inappropriate for START enrollment

☐ More information needed to determine if individual is eligible for START services/No documentation provided

☐ Individual/guardian not interested in services

| Contact tracking | Date/time | Person Contacted | Outcome |
| --- | --- | --- | --- |
| Date/time of 1st attempt to contact |  |  |  |
| Date/time of 2nd attempt to contact |  |  |  |
| Date/time of 3rd attempt to contact |  |  |  |
| Outreach letter sent: |  |  |  |