

## Directions: Please read carefully to expedite processing

To be eligible for I-Start Clinical Services, an individual must have a diagnosed Intellectual and/or Developmental Disability and be at least 18 years old.

Please email the following forms to istart@elevateccbhc.org or fax to 515-220-2272. The requested documentation is essential to determine eligibility, missing documentation will delay processing. Additionally, all records are reviewed internally prior to the formal I-START intake meeting.

(1) I-START referral form

(3) Proof of Diagnosis + Pertinent client record information

(4) Release of Information to referring agency

(5) Signed Consent to Treatment

(6) Client Handbook Acknowledgement Form

(5) Copy of:

 Photo ID (if applicable)

 Social Security card

 Insurance card

Once an individual is determined eligible for I-START Clinical Services, an I-START team member will be in contact with you.

## Pertinent Records Requested Include:

• Current Service Plans

• Current Medications

• Social History

• Any Assessments

• Behavioral Plan

• Clinical Reports, Consultation and/or case summaries

• Guardianship papers (permission granted to referral to program)

**I-START Referral**

START Screening & Referral

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

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

Individual/Caregiver reliable Access to Technology

[ ]  Telephone/Landline

[ ]  Cell phone service

[ ]  Smart Phone

[ ]  High Speed Internet

[ ]  Hot Spot

[ ]  Laptop/desktop

[ ]  Tablet

[ ]  Other

Employment Status

[ ]  Day/Vocational

[ ]  Supported Employment

[ ]  Student

[ ]  Employment Full Time

[ ]  Employment Part Time

[ ]  Volunteer

[ ]  Not Employed

Services at Enrollment

[ ]  Adult Protective Services

[ ]  Child Protective Services

[ ]  Behavioral Support Services

[ ]  Case Management/Service Coordination

[ ]  Day Services/Program

[ ]  Employment Services

[ ]  Enhanced Staffing (1:1 or 2:1)

[ ]  Mental Health Outpatient Services

[ ]  Respite

[ ]  Vocational/Prevocational Services

[ ]  None

Funding Source (check all that apply)

[ ]  Intellectual Disability Waiver

[ ]  Brain Injury Waiver

[ ]  Habilitation

[ ]  Medicaid

[ ]  Medicare

[ ]  Private Insurance

[ ]  None

[ ]  Other

Diagnostic Information and Reason for Referral

DSM 5 Diagnosis

|  |  |
| --- | --- |
| Psychiatric Diagnosis: |  |
| IDD Diagnosis: | [ ]  Normal Intelligence [ ]  Mild (50-70) [ ]  Severe (20-34)[ ]  Borderline (71-84) [ ]  Moderate (35-49) [ ]  Profound (<20) |
| Medical/Health Conditions: |  |
| Social Stressors: |  |

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?

|  |
| --- |
|  |

Emergency Service Utilization History

|  |  |  |
| --- | --- | --- |
|  **Report the number of visits/stay in past 12 month and in past 5 years** | 12 months | 5 Years |
| Psychiatric hospitalizations |  |  |
| Emergency department visits |  |  |
| Law enforcement encounters |  |  |
| ICF/DD stays |  |  |
| Jail stays |  |  |
| Number of different living situations |  |  |

Referral Information

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

Referral Source

[ ]  Case Manager/Service

 Coordinator

[ ]  Community psychiatric inpatient

[ ]  Day/Vocational service provider

[ ]  Emergency services/Mobile

 Crisis Team or Access Center

[ ]  Family member

[ ]  Friend

[ ]  Hospital emergency department

[ ]  Law enforcement

[ ]  Legal advocate

[ ]  Legal Guardian (non-familial)

[ ]  Mental health professional

[ ]  Residential provider

[ ]  School

[ ]  Self

[ ]  State operated I/DD center

[ ]  State psychiatric hospital

[ ]  Other

Caregiver and Team Information

Primary Caregiver

[ ]  Parent

[ ]  Other Family Member

[ ]  Paid Support Staff

[ ]  Self

[ ]  Guardian

[ ]  Other: \_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | Email |  |
| Phone  |  | Address  |  |
| Has primary caregiver been informed and is supportive of this referral? | [ ]  Yes [ ] No; provide explanation Click or tap here to enter text. |

Secondary Caregiver

[ ] **Yes,** *indicate type below* [ ]  **No**

[ ]  Parent

[ ]  Other Family Member

[ ]  Paid Support Staff

[ ]  Self

[ ]  Guardian

[ ]  Other: \_\_\_\_\_\_\_\_\_

Team Contact Information

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **Role** | **Email** | **Phone** |
|  | Family |  |  |
|  | Guardian |  |  |
|  | Residential/SCL Provider |  |  |
|  | Day/Vocational |  |  |
|  | Case Manager |  |  |
|  | Primary Doctor |  |  |
|  | Psychiatrist |  |  |
|  | Therapist |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Thank you!**

We look forward to collaborating with you!

The *I-START* Team

**Eligibility Documentation Checklist**

|  |
| --- |
| Required Documentation |
| Proof of Diagnosis: at least one of the following  [ ]  Psychological evaluation [ ]  Psychiatric Evaluation  [ ]  DD checklist + Other Supporting Documentation  |
| [ ]  Elevate Release of Information  |
| [ ]  Consent to treat |
| [ ] Client Handbook Acknowledgement |
| [ ]  Copy of Photo ID |
| [ ]  Copy of Social Security Card |
| [ ]  Copy of Insurance Card |
| [ ]  Other:  |

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

Suitability of enrollment in START:

[ ]  Appropriate [ ]  Inappropriate Reason: Click or tap here to enter text.

**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: |  |  |  |