

## 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](mailto: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: |  |  |  |