NATIONAL CENTER FOR START SERVICES

START Screening & Referral

Date: Time of Referral:

Person's Name:		**DOB:**	
MCI number:		**Medicaid number:**	
Gender:	☐ Male ☐ Female ☐ Non-Binary ☐ Questioning ☐ Prefer not to answer		
Pronouns:			
Address		County:	
City/State		Zip	

For children under the age of 18:

Who child lives with:		Custody Status:	

Demographics

Race/Ethnicity

☐ American Indian or Alaskan Native
☐ Asian
☐ Black or African American
☐ Hispanic/Latino
☐ Middle Eastern or North African
☐ Native Hawaiian or Pacific Islander
☐ White
☐ Two or more races
☐ Prefer not to answer
☐ Self-Describe (other):

Language

☐ English
☐ Spanish
☐ American Sign Language (ASL)
☐ Arabic
☐ Bengali
☐ Chinese-Cantonese
☐ Chinese-Mandarin
☐ French
☐ German
☐ Haitian/Creole
☐ Hindi
☐ Italian
☐ Japanese
☐ Korean
☐ Nepalese
☐ Polish
☐ Portuguese
☐ Russian
☐ Tagalog
☐ Urdu
☐ Vietnamese
☐ Other:

Person/Caregiver Reliable Access to Technology

☐ Telephone landline
☐ Cell phone service
☐ Smartphone
☐ High Speed Internet
☐ Hot Spot
☐ Laptop/desktop
☐ Tablet
☐ Other

Living Situation at Enrollment

☐ Alternative Family Living (AFL)/Enhanced Family Care (EFC)/Host Home
☐ Assisted Living Facility
☐ Community ICF/DD
☐ Facility-based residential setting
☐ Family/relative home
☐ Foster care home
☐ Group home
☐ Homeless, sheltered
☐ Homeless, unsheltered
☐ Independent living
☐ Jail
☐ Psychiatric hospital
☐ State operated IDD center
☐ Supervised apartment
☐ Supported living
☐ Other:

Has this person had ***more than one*** living situation over the last year? ☐ Yes / ☐No If yes, number:
Has this person had ***more than one*** living situation over the last 5 years? ☐ Yes / ☐No

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Referral Information

Referred by:		Agency if applicable	
Email Address:		Phone:	

Referral Source

- ☐ Case Manager/Service Coordinator
- ☐ Community psychiatric inpatient
- ☐ Emergency services/Mobile crisis
- ☐ Day/Vocational service provider
- ☐ Family member
- ☐ Other: _____
- ☐ Friend
- ☐ Hospital emergency depart.
- ☐ Law enforcement
- ☐ Legal Guardian (non-familial)
- ☐ Mental Health Professional
- ☐ Residential provider
- ☐ School
- ☐ Self
- ☐ State operated IDD center
- ☐ State psychiatric hospital

Reason for Referral

- ☐ Aggression (physical, verbal, property destruction, threats)
- ☐ Decrease in ability to participate in daily functions
- ☐ At risk of losing placement
- ☐ Diagnosis and treatment planning
- ☐ Family needs assistance
- ☐ Leaving unexpectedly
- ☐ Mental health symptoms
- ☐ Self-injurious
- ☐ Unsafe sexualized behavior
- ☐ Suicidal ideation
- ☐ Suicidal action
- ☐ Transition support
- ☐ 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 concerns: What services/supports are you looking for by making this referral?

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Caregiver Information

Primary Caregiver

☐ Parent ☐ Guardian/Authorized Rep ☐ Self
☐ Other Family Member ☐ Paid Support Staff ☐ Other

Name:		Relationship:	
Email:		Phone:	
Address:			

Guardian Information (if different than primary caregiver information, listed above

☐ Parent ☐ Guardian/Authorized Rep ☐ Self
☐ Other Family Member ☐ Paid Support Staff ☐ Other

Name:		Relationship:	
Email:		Phone:	
Address:			
Verbal consent* from Guardian?	☐ Yes / ☐ No *START is a voluntary service; consent to share information and to pursue referral must be obtained from legal guardian prior to review		

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

☐ Parent ☐ Guardian/Authorized Rep ☐ Self
☐ Other Family Member ☐ Paid Support Staff ☐ Other

Name:		Relationship:	
Email:		Phone:	
Address:			

Additional Team Contact Information

Name:	Role:	Email:	Phone:

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Diagnosis

Psychiatric Diagnosis:	
Neurodevelopmental Disorder (NDD):	
Medical/Health Diagnoses:	
Psycho Social Stressors: *social factors that may have an impact on the person referred to START; examples include: history of trauma, recent hospitalizations, housing insecurity	

Level of ID

☐ Normal intelligence
☐ Borderline
☐ Mild
☐ Moderate
☐ Severe
☐ Profound
☐ None noted

Documentation

Documentation Checklist

Required Documentation		Date received
DBHIDS consent form	☐ Yes ☐ No	
Individual Support Plan	☐ Yes ☐ No	
Psychological evaluation with FSIQ or Autism Assessment	☐ Yes ☐ No	
Adaptive Functioning Assessment	☐ Yes ☐ No	
Individual Education Plan (if applicable)	☐ Yes ☐ No	
Behavioral Support Plan (if applicable)	☐ Yes ☐ No	
Transition Plan (if applicable)	☐ Yes ☐ No	
Other:		

To be completed by
Department of Behavioral Health and Intellectual Disability Services

DBHIDS representative:		Date Received:	
Referral to START	☐ Yes ☐ No		
If no, rationale:			

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To be completed by JEVS Philadelphia START program

Person's Name:		**DOB:**	
MCI number:			

Disposition:

Brief Summary and Impressions (include START goals and needs to be addressed):

START Team member completing disposition:		**Date of completion:**	

☐ **Accepted for START Enrollment**

Coordinator Assigned		Date:	

☐ **More information needed to determine eligibility for START services/No documentation provided.**

Date documentation obtained:		Accepted:	☐Yes ☐ No

☐ **Accepted but person/guardian not interested in services.**

☐ **Inappropriate for START enrollment. Reason: _____**

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:			