

START Screening & Referral

Date: _____ Time of Referral: _____

Person's Name:		DOB:	
MCI number:		Medicaid number:	
Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-Binary <input type="checkbox"/> Questioning <input type="checkbox"/> 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

- | | | |
|--|--|---|
| <input type="checkbox"/> American Indian or Alaskan Native | <input type="checkbox"/> Middle Eastern or North African | <input type="checkbox"/> Two or more races |
| <input type="checkbox"/> Asian | <input type="checkbox"/> Native Hawaiian or Pacific Islander | <input type="checkbox"/> Prefer not to answer |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> White | <input type="checkbox"/> Self-Describe (other): |
| <input type="checkbox"/> Hispanic/Latino | | |

Language

- | | | |
|---|---|-------------------------------------|
| <input type="checkbox"/> English | <input type="checkbox"/> French | <input type="checkbox"/> Polish |
| <input type="checkbox"/> Spanish | <input type="checkbox"/> German | <input type="checkbox"/> Portuguese |
| <input type="checkbox"/> American Sign Language (ASL) | <input type="checkbox"/> Haitian/Creole | <input type="checkbox"/> Russian |
| <input type="checkbox"/> Arabic | <input type="checkbox"/> Hindi | <input type="checkbox"/> Tagalog |
| <input type="checkbox"/> Bengali | <input type="checkbox"/> Italian | <input type="checkbox"/> Urdu |
| <input type="checkbox"/> Chinese-Cantonese | <input type="checkbox"/> Japanese | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> Chinese-Mandarin | <input type="checkbox"/> Korean | <input type="checkbox"/> Other: |
| | <input type="checkbox"/> Nepalese | |

Person/Caregiver Reliable Access to Technology

- | | | |
|---|--|---------------------------------|
| <input type="checkbox"/> Telephone landline | <input type="checkbox"/> High Speed Internet | <input type="checkbox"/> Tablet |
| <input type="checkbox"/> Cell phone service | <input type="checkbox"/> Hot Spot | <input type="checkbox"/> Other |
| <input type="checkbox"/> Smartphone | <input type="checkbox"/> Laptop/desktop | |

Living Situation at Enrollment

- | | | |
|---|--|--|
| <input type="checkbox"/> Alternative Family Living (AFL)/Enhanced Family Care (EFC)/Host Home | <input type="checkbox"/> Family/relative home | <input type="checkbox"/> Jail |
| <input type="checkbox"/> Assisted Living Facility | <input type="checkbox"/> Foster care home | <input type="checkbox"/> Psychiatric hospital |
| <input type="checkbox"/> Community ICF/DD | <input type="checkbox"/> Group home | <input type="checkbox"/> State operated IDD center |
| <input type="checkbox"/> Facility-based residential setting | <input type="checkbox"/> Homeless, sheltered | <input type="checkbox"/> Supervised apartment |
| | <input type="checkbox"/> Homeless, unsheltered | <input type="checkbox"/> Supported living |
| | <input type="checkbox"/> Independent living | <input type="checkbox"/> 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

Referral Information

Referred by:		Agency if applicable	
Email Address:		Phone:	

Referral Source

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

Reason for Referral

- | | |
|---|---|
| <input type="checkbox"/> Aggression (physical, verbal, property destruction, threats) | <input type="checkbox"/> Self-injurious |
| <input type="checkbox"/> Decrease in ability to participate in daily functions | <input type="checkbox"/> Unsafe sexualized behavior |
| <input type="checkbox"/> At risk of losing placement | <input type="checkbox"/> Suicidal ideation |
| <input type="checkbox"/> Diagnosis and treatment planning | <input type="checkbox"/> Suicidal action |
| <input type="checkbox"/> Family needs assistance | <input type="checkbox"/> Transition support |
| <input type="checkbox"/> Leaving unexpectedly | <input type="checkbox"/> Other |
| <input type="checkbox"/> Mental health symptoms | |

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?

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?	<input type="checkbox"/> Yes / <input type="checkbox"/> No <small>*START is a voluntary service; consent to share information and to pursue referral must be obtained from legal guardian prior to review</small>		

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:

Diagnosis

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

Level of ID

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

Documentation

Documentation Checklist

Required Documentation		Date received
DBHIDS consent form	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Individual Support Plan	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Psychological evaluation with FSIQ or Autism Assessment	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Adaptive Functioning Assessment	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Individual Education Plan (if applicable)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Behavioral Support Plan (if applicable)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Transition Plan (if applicable)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other:		

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:	<input type="checkbox"/> Yes <input type="checkbox"/> 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:			