

COMMUNITY PRE VOC REFERRAL FORM

INDIVIDUAL'S LAST NAME: _____

Welcome to Starbridge!

Please complete all sections of this referral form. If an area is not applicable, please type or write "N/A" to indicate that a section was not overlooked.

All required documents on page 5 must be included before this form will be reviewed.

To return this form by mail, please send to:

Starbridge Services, Inc.
Attn: Community Pre Voc
1650 South Ave, Suite 200
Rochester, NY 14620

This form and supporting documents can be emailed to jpardi@starbridgeinc.org or faxed to (585) 224-7124.

Please allow ten business days for us to acknowledge receipt. We will contact you with questions or to discuss next steps.

If you have any questions, please do not hesitate to contact us by email or phone at (585) 224-7224.

ABOUT THE INDIVIDUAL

Name		Date of Birth:
Address		
Home phone	Mobile phone	Email address
Social Security #	Medicaid # TABS ID #	Race and/or Ethnicity:
Current living arrangement: <input type="checkbox"/> Independent/Alone <input type="checkbox"/> With Family or Friends <input type="checkbox"/> Certified Setting If selected, specify operating agency:		

Does the individual have eligibility through OPWDD? YES NO

Has the individual been approved for requested services? YES NO

What actions are pending for approval? _____

Anticipated date that pending actions will be addressed: _____

Who is the individual's guardian?		
Self: <input type="checkbox"/>	Parent(s) or Family: <input type="checkbox"/> <i>Provide name(s) below</i>	Other: <input type="checkbox"/> <i>Provide name(s) below</i>
Guardian Name(s):		
Relation to individual:		
Current address (if different from individual's):		
Current phone #:	Current email:	



Emergency Contact Name(s):	
Relation to individual:	
Current address:	
Current phone #:	Current email:

Care Coordinator Name:	
Agency:	
Agency address:	
Phone #:	Email:

Broker Name:	
Agency:	
Agency address:	
Phone #:	Email:

Physician Name:	
Physician address:	
Phone #:	Email:
Preferred Hospital:	

Therapist Name:	
Hospital/Agency:	
Address:	
Phone #:	Email:

Medical Information:			
Primary Diagnosis:			
Additional Diagnosis:			
Medications			
Name of Medication	Dosage	Frequency or Times	Purpose



Other Direct Service Provider(s):	
Name, Address, Phone, Email	Services provided

Other Involved Natural Supports:	

Current Representative Payee Name:	
Relationship to individual:	
Address:	
Phone #:	Email:

Has the individual had any involvement with the criminal justice system? YES NO

If yes, please describe charges, time served, probation, parole, etc.

Current Daily Activities (include day programs and work)		
Activity	Days & Times	Location

Interests & Hobbies (what does the individual enjoy?):



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Level of Independence:			I = Independent	S = Some Support/Supervision	T = Total Support Necessary		
Personal Hygiene	<input type="checkbox"/> I	<input type="checkbox"/> S	<input type="checkbox"/> T	Eating	<input type="checkbox"/> I <input type="checkbox"/> S <input type="checkbox"/> T	Dressing	<input type="checkbox"/> I <input type="checkbox"/> S <input type="checkbox"/> T
Telephone	<input type="checkbox"/> I	<input type="checkbox"/> S	<input type="checkbox"/> T	Money Management	<input type="checkbox"/> I <input type="checkbox"/> S <input type="checkbox"/> T	Laundry	<input type="checkbox"/> I <input type="checkbox"/> S <input type="checkbox"/> T
Cooking	<input type="checkbox"/> I	<input type="checkbox"/> S	<input type="checkbox"/> T	Shopping	<input type="checkbox"/> I <input type="checkbox"/> S <input type="checkbox"/> T	Transportation	<input type="checkbox"/> I <input type="checkbox"/> S <input type="checkbox"/> T
Able to exit independently in case of fire? YES <input type="checkbox"/> NO <input type="checkbox"/>							
Comments:							
What type of supervision/assistance does the individual need in the community?							
Which skills need development?							

Mobility: (check all that apply)		
<input type="checkbox"/> Fully ambulatory	<input type="checkbox"/> Can negotiate stairs	<input type="checkbox"/> Uses manual wheelchair
<input type="checkbox"/> Walks with assistive device	<input type="checkbox"/> Can bear weight	<input type="checkbox"/> Uses power wheelchair
<input type="checkbox"/> Walks with difficulty	<input type="checkbox"/> Requires use of a lift	<input type="checkbox"/> Requires wheelchair accessible van
Does the individual drive or use public transportation independently? YES <input type="checkbox"/> NO <input type="checkbox"/>		
Does the individual use public transportation with assistance? YES <input type="checkbox"/> NO <input type="checkbox"/>		
Will the individual require training in the use of public transportation? YES <input type="checkbox"/> NO <input type="checkbox"/>		

Preferred Staff:
<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> No preference

Additional information (i.e., medical concerns, requested accommodations, etc.):



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Please attach all documents listed and submit with this referral form.

Document	Effective Date
<input type="checkbox"/> Psychological Evaluation	
<input type="checkbox"/> Life Plan	
<input type="checkbox"/> Residential IPOP	
<input type="checkbox"/> Social Work History	
<input type="checkbox"/> IEP (if applicable)	
<input type="checkbox"/> Complete Physical Exam (must be dated within last 12 months, including list of current medications)	
<input type="checkbox"/> Client-specific Medication Information Sheets	
<input type="checkbox"/> Proof of PPD (within last 12 months)	
<input type="checkbox"/> DDP-2	
<input type="checkbox"/> Psychiatric Evaluation (if applicable)	
<input type="checkbox"/> Behavior Plan (if applicable)	
<input type="checkbox"/> Sexuality Assessment	
<input type="checkbox"/> Work History/Resume/Performance Evaluation	
<input type="checkbox"/> Day Program/Vocational Goals	
<input type="checkbox"/> Copies of Social Security/Medicaid/Medicare/Private Health Insurance Cards	
<input type="checkbox"/> Copies of Guardianship Paperwork (if applicable)	
<input type="checkbox"/> OPWDD HCBS Waiver Authorization Letter	
<input type="checkbox"/> Other:	

SIGNATURES REQUIRED:

Individual Date

Guardian (If applicable) Date

Broker or Care Coordinator Date

Starbridge Staff Reviewer Date

Information provided by: _____

Agency: _____

Phone #: _____

Date Completed: _____

APPROVAL (FOR STARBRIDGE USE ONLY)

Date Received: _____

Approved Not Approved

Starbridge Staff Signature: _____

Comments/Additional Information Requested:

