COM HAB 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 Habilitation
1650 South Ave, Suite 200
Rochester, NY 14620

This form and supporting documents can be emailed to kcannan@starbridgeinc.org or faxed to (585) 224-7111.

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) 224-7211.

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: ○ Independent/Alone ○ With Family or Friends		○ 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: ○	Parent(s) or Family: ○ *Provide name(s) below*	Other: ○ *Provide name(s) below*
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?):

Level of Independence: I = Independent S = Some Support/Supervision T = Total Support Necessary		
Personal Hygiene ☐ I ☐ S ☐ T	Eating ☐ I ☐ S ☐ T	Dressing ☐ I ☐ S ☐ T
Telephone ☐ I ☐ S ☐ T	Money Management ☐ I ☐ S ☐ T	Laundry ☐ I ☐ S ☐ T
Cooking ☐ I ☐ S ☐ T	Shopping ☐ I ☐ S ☐ T	Transportation ☐ I ☐ S ☐ T
Able to exit independently in case of fire? YES ◯ NO ◯		
Comments:		
What type of supervision/assistance does the individual need in the community?		
Current Service Needs: Which skills need development? (specify in detail)		

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

Preferred Staff:
◯ Female ◯ Male ◯ No preference

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

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INDIVIDUAL'S LAST NAME:_____

Please attach all documents listed and submit with this referral form.	
Document	**Effective Date**
☐ Psychological Evaluation	
☐ Life Plan	
☐ Residential IPOP (if applicable)	
☐ Social Work History	
☐ IEP (if applicable)	
☐ Complete Physical Exam (must be dated within last 12 months, including list of current medications	
☐ Client-specific Medication Information Sheets	
☐ Proof of PPD (within last 12 months)	
☐ DDP-2	
☐ Psychiatric Evaluation (if applicable)	
☐ Behavior Plan (if applicable)	
☐ Sexuality Assessment	
☐ Day Program/Vocational Goals (if applicable)	
☐ Copies of Social Security/Medicaid/Medicare/Private Health Insurance Cards	
☐ Copies of Guardianship Paperwork (if applicable)	
☐ OPWDD HCBS Waiver Authorization Letter	
☐ 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: