

**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 noted on page 4 must be included before this form will be reviewed.

To return this questionnaire by mail, please send to:

Starbridge Services, Inc.  
 Attn: FI Department  
 1650 South Ave, Suite 200  
 Rochester, NY 14620

To return via email, please send to **FiSupport@starbridgeinc.org**

Please allow ten business days for us to acknowledge receipt. Once we receive the completed package, we will review and determine whether we can meet your needs with our service. We will contact you with our decision and to discuss next steps. If you have any questions, please do not hesitate to contact us by email or phone at (585) 224-7232.

**ABOUT THE INDIVIDUAL**

Name		Date of Birth:
Address		
Home phone	Mobile phone	Email address
Social Security #	Medicaid #	TABS ID #
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:		

**Demographic Information**

Funders are increasingly requesting information from nonprofits and human service agencies regarding the demographics of staff, Board members, and people we serve. Personally identifiable information will be kept confidential. Any demographics shared will be for reporting purposes only and will be kept anonymous.

**Race/Ethnicity (choose all that apply):**

- Asian American/Asian
- Black/African American/African
- Hispanic or Latino/a/x
- Middle Eastern
- Native American/American Indian/Alaskan Native
- Native Hawaiian/Pacific Islander
- White/Caucasian/European
- Other racial/ethnic identity \_\_\_\_\_
- Prefer not to disclose

**Gender Identity:**

- Female
- Male
- Transgender
- Nonbinary or nonconforming
- Other identity \_\_\_\_\_
- Prefer not to disclose



We use an electronic database for staff timesheets, billing notes, and expense reporting. Do the individual, their guardian, and circle of support have internet access? YES  NO

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: \_\_\_\_\_

Has the individual attended an OPWDD Self-Direction workshop? YES  NO  Date of attendance: \_\_\_\_\_

Does the individual have an active self-directed budget? YES  NO

If YES:

Provide the name of the FI current agency: \_\_\_\_\_

Does the individual have staff that work for another agency? YES  NO

If NO:

What is the projected start date of budget/services? \_\_\_\_\_

Does the individual anticipate using their budget to self-hire staff? YES  NO

Is anyone else in the individual's family/household currently using Starbridge FI Services? YES  NO

If YES, please provide the name of the family or household member: \_\_\_\_\_

NOTE: At this time, Starbridge does not provide support for these services: SEMP Self-hire, Live in Caregiver.

<b>Who is the individual's guardian?</b>		
Self <input type="checkbox"/>	Parent(s) or Family <input type="checkbox"/> Name(s):	Other <input type="checkbox"/> Name(s):

<b>Guardian Name(s):</b>	
Relation to individual:	
Current address (if different from individual's):	
Current phone #:	Current email:

<b>Care Coordinator Name:</b>	
Agency:	
Agency address:	
Phone #:	Email:

<b>Broker Name:</b>	
Agency:	
Agency address:	
Phone #:	Email:



<b>Emergency Contact Name(s):</b>	
Relation to individual:	
Current address:	
Current phone #:	Current email:

<b>Other Direct Service Provider(s):</b>	
<b>Name, Address, Phone, Email</b>	<b>Services provided</b>

<b>Current Representative Payee Name:</b>	
Relationship to individual:	
Address:	
Phone #:	Email:

<b>Other Involved Natural Supports:</b>	



**LIST OF REQUIRED DOCUMENTS**

- Self-Direction Authorization Letter
- Proof of attendance for Self-Direction session
- NOD
- DDSO Waiver Approval
- Broker Agreement
- LCED
- Copy of DDP-2
- Copies of legal guardian paperwork (if applicable)
- Psychological evaluation
- Most recent ISP
- ISP Addendum adding all applicable waiver services is required before the budget will be submitted for approval.
  - Valued outcome: “ \_\_\_\_\_ would like to utilize a broker and FI to self-direct services.”
  - Waiver listings:
    - Starbridge Services, Inc. Fiscal Intermediary, Frequency: Monthly, Effective date: Pending
    - Starbridge Services, Inc. Support Broker, Frequency: Hourly, Effective date: Pending

**SIGNATURES REQUIRED:**

\_\_\_\_\_  
Individual (preferred but not required)                      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:

