THE CENTER FOR START SERVICES
Institute on Disability / UCED
University of New Hampshire

START Screening & Referral

Date: Time of Referral: Length of Contact:

Individual's Name:		DOB:	
Gender:	☐ Male ☐ Female ☐ Self-Describe:		
Legal Guardian?	☐ Yes ☐ No	Lives with Guardian:	☐ Yes ☐ No
Address		County:	
City/State		Zip	

For children under the age of 18:

Who child lives with:		Custody Status:	

Demographics

Race

☐ African American/Black
☐ American Indian/Alaskan
☐ Asian
☐ Hawaiian/Pacific Islander
☐ White
☐ Other:

Ethnicity

☐ Hispanic
☐ Non-Hispanic
☐ Unknown

Primary Language

☐ English
☐ Spanish
☐ Sign Language
☐ Other:

Living Situation

☐ Assisted Family Living (AFL)
☐ Assisted Living Facility
☐ Community ICF/DD
☐ Family home
☐ Foster care home
☐ Group home
☐ Homeless, sheltered
☐ Homeless, unsheltered
☐ Independent living
☐ Jail
☐ Psychiatric hospital
☐ State operated I/DD center
☐ Supervised apartment
☐ Supported living
☐ Other:

Referral Information

Referred by:		Agency if applicable	
Email Address:		Phone:	

Referral Source

☐ Case Manager/Service Coordinator
☐ Community psychiatric inpatient
☐ Day/Vocational service provider – community
☐ Emergency services/Mobile crisis team
☐ Family member
☐ Friend
☐ Hospital emergency department
☐ Law enforcement
☐ Legal advocate
☐ Legal Guardian (non-familial)
☐ Mental health professional
☐ Residential provider - Community
☐ School
☐ Self
☐ State operated I/DD center
☐ State psychiatric hospital
☐ Other

QA Approved January 2021

Presenting Problems at Referral (check all that apply)

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

Caregiver Information

Primary Caregiver

☐ Parent
☐ Other Family Member
☐ Paid Support Staff
☐ Self
☐ Guardian/Authorized Representative
☐ Other: _____

Name:		Relationship:	
Email:		Phone**:**	
Address:			
Speak with Guardian?	☐ Yes / ☐ No	**Left a message at (date/time):** _____	

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

☐ Parent
☐ Other Family Member
☐ Paid Support Staff
☐ Guardian/Authorized Representative
☐ Self
☐ Other: _____

Diagnostic Information

Level of ID

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

DSM 5 Diagnosis

Psychiatric Diagnosis:	
IDD Diagnosis:	
Medical/Health Conditions:	
Social Stressors:	

Documentation & Disposition

Team Contact Information

Name:	Role:	Email:	Phone:

Documentation Checklist

Required Documentation	Date received
Psychological evaluation with FSIQ ☐ Yes ☐ No	
Adaptive Functioning Assessment ☐ Yes ☐ No	
Other Documentation (list)	

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

Print name/title Signature Date

Suitability of enrollment in START:

☐ Appropriate ☐ Inappropriate Reason:

Disposition:

☐ Accepted for START Enrollment

Coordinator Assigned		Date:	

☐ Inappropriate for START enrollment

☐ More information needed to determine if individual is eligible for START services/No documentation provided

☐ Individual/guardian not interested in services

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:			