

Date of Referral: _____

SECTION II: SYSTEM OF SUPPORT CONTACTS

If over 18, has the applicant been No *(Provide contact for identified primary support person under section below)*
adjudicated incompetent? Yes Type of Guardianship: _____
County Adjudicated: _____ Date of Qualification: _____

Legally Responsible Person/Agency: _____

Address: _____
Street/Mailing City State ZIP Code

Home Phone: _____ Work Phone: _____ Cell Phone: _____
E-Mail Address: _____

Name: _____ Relationship: _____

Address: _____
Street City State ZIP Code

Home Phone: _____ Work Phone: _____ Cell Phone: _____
E-Mail Address: _____

Name: _____ Relationship: _____

Address: _____
Street City State ZIP Code

Home Phone: _____ Work Phone: _____ Cell Phone: _____
E-Mail Address: _____

Name: _____ Relationship: _____

Address: _____
Street City State ZIP Code

Home Phone: _____ Work Phone: _____ Cell Phone: _____
E-Mail Address: _____

Comments on support network:

SECTION III: OVERVIEW OF NEED

Include date, score, and assessment type for IQ

Intellectual/Developmental Disability:

Include age of diagnosis, subtype, sensory needs

Autism Spectrum Disorder:

Psychiatric Diagnoses:

Medical Diagnoses:

Social Stressors and/or Trauma History:

Self-Care Skills: I=Independent VP=Verbal Prompt PA=Physical Assistance TD=Total Dependence

- _____ Eating/Drinking
- _____ Toileting
- _____ Bathing/Grooming
- _____ Dressing/Undressing, including closures
- _____ Teeth Brushing
- _____ Hand washing

Mobility:

- Independent
- Requires Assistance
- Non-Ambulatory/Mobile
- Non-Ambulatory/Non-Mobile

Life Skills: I=Independent VP=Verbal Prompt PA=Physical Assistance TD=Total Dependence

- _____ Choosing/Preparing Simple foods
- _____ Household Chores (dishes, laundry, making bed, etc.)
- _____ Making Phone Calls
- _____ Pedestrian Safety Skills
- _____ Making Simple Purchases

Date of Referral:

Communication/Language:

Expressive:

- Uses expressive language Mode: Verbal Sign Language Gesture
- Uses communication device Specify Type:

Receptive:

- Comprehends verbal language Attends to gestures and auditory cues Attends to visual cues
- Does not respond to communication

Describe how the applicant makes his/her wants and needs known:

Socialization:

- Initiates interaction Responds to interaction Avoids interaction
- No response to interaction Prefers interaction with males Prefers interaction with females

Sexual Awareness:

Is the applicant aware of his/her sexuality? Yes No Sexually active? Yes No

If yes to either above, describe any concerns or matters we should know in order to support the applicant:

Leisure:

Favorite Leisure Activities

SECTION IV: BEHAVIORAL HEALTH NEEDS

Is there a current behavior support plan? Yes – Psychologist name/contact:
 No – Reason:

BEHAVIOR	FREQUENCY How often does this occur?	DESCRIPTION What does this look like for this person?
Verbal Aggression		
Physical Aggression		
Property Destruction		
Elopement/Wandering		
Self-Injurious Behavior		
Inappropriate Sexual Behavior		
PICA		

Has the applicant been charged with and/or convicted of any criminal offenses? Yes* No
(*If Yes, please complete Legal History form)

SECTION V: CURRENT SUPPORTS AND SERVICES

NC START Involvement:

Region: _____ Date of Referral: _____ Outcome of Referral: _____
Coordinator Name (if active): _____ Phone # _____

Education:

Is the applicant currently in school? No – Highest Grade/Program Completed:
 Yes – Complete the following and IEP must be included with referral

Name of School: _____ Current Grade: _____
Contact Name: _____ Phone # _____

Classroom Setting: Integrated Self-Contained 1:1 Home-Based (# of Hours: _____)

Vocation/Day Activity:

Describe applicant's daily schedule. Include employment history as appropriate.

Active Services (currently working with the applicant):

Provider	Service/Hours	Date of Auth	Notes (How effective is the support provided?)