REFERRAL APPLICATION FOR

PROGRAM SERVICES

501 6th St. W.
Browerville, MN 56438
Phone: (320) 594-6423
Fax: 320-594-6427
E-mail: coryl@stepstaff.org

Name: ____

Date STEP Received:

____

Referral For:

_____ **Day Training and Habilitation (DT&H)**

_____ **Supported Employment (SE)**

_____ **Structured Day Program (SDP-TBI)**

_____ **Pre Vocational Services**

PERSONAL INFORMATION

Name: ______________________________ ___________________________ _______________________
Last First Middle Initial

Address: ______________________________ ____________________ _________ ____________
Street City State Zip

_______________________ ____________________ ______________ _____________________
Home Phone Number Cell Phone Number Birthdate Social Security Number

__________ _________________ ____________ _____________ ____________
Age Marital Status Height Weight Gender

Please check the following boxes if you have these documents:

☐Identification Card ☐Social Security Card/Birth Certificate

Please have these documents available at the admission meeting.

(Please attach a Social History if available)

PLACEMENT INFORMATION

Reason for Referral: ____

____

____

Expected Service Outcome: ____

Date Services Needed by: ____

Case Manager/Agency Making Referral: ____

Phone/Fax Number: ________________________________ Email: _______________________

Address: ______________________________ ____________________ _________ ____________
Street City State Zip

(Please attach a current CSSP and Discharge Summary if available)

MEDICAL DIAGNOSIS

Date of Onset of Primary Disability: ____

Primary Diagnosis: _________________________________ Diagnosis Code: __________________________

Secondary Diagnosis: _______________________________ Diagnosis Code: __________________________

Tertiary Diagnosis: _________________________________ Diagnosis Code: __________________________

(Please attach Psychological/Psychiatric evaluation if available)

SUPPORT SERVICES

Check those services expected to be provided by STEP.

(Please provide evaluations, assessments, reports or documents relative to current service needs)

SERVICE	NEEDS	EXPLANATION
Behavioral Programming		
Dietary		
Life Safety/Self Preservation		
Medical Specialist		
Nursing		
Occupational Therapy		
Physical Therapy		
Pre-Vocational (DT&H)		
Psychiatric Counseling		
Psychological		
Structured Day Program (SDP)		
Supported Employment (SE)		
Transportation		
Work Activity (DT&H)		
Other (Specify)		

Please list any support services this individual has received in the past 3 years which they are not currently receiving:

____

____

____

____

____

____

ENVIRONMENTAL CONSIDERATIONS

REQUIRES	NEEDS	EXPLANATION
Barrier Free Physical Plant		
Van with Lift		
Smoking Area		
Quiet Time Area		
Other (specify)		

AMBULATION

Check those which apply

Walks Alone _____ Yes _____ No

Walks with Support _____ Yes _____ No

Uses a Walker _____ Yes _____ No

Uses a wheelchair _____ Yes _____ No

STAFFING PATTERNS

Provide the minimum staff ratio:

Day Program	
Residence	
Able to be home alone?	

SCHEDULE OF ATTENDANCE

Five days per week: ____

Other (Please specify): ____

MEDICATIONS

If consumer self-administers medications, please provide current program, or documentation of past training. (Attach list if available)

Current Medication	Dose	Schedule	Purpose	Self Administered yes / no

Does Applicant:
Wear hearing aids? Yes__________No_________
Wear glasses? Yes__________No_________
Have dentures? Yes__________No_________
Date of last physical exam (copy of):______________________________
Date of last psychological exam (copy of):_________________________
Date of last speech test (copy of):________________________________
Special dietary needs: Yes__________No_________
List needs:
1. ____
2. ____

IMMUNIZATIONS

(Please attach a list of immunizations if available)

SEIZURES

Has this person ever had seizures? _________ Yes _________ No
Has this person ever gone into status epilepticus? _________ Yes _________ No

Describe seizure activity: ____

____

Number of seizures in the past year: ____

SENSITIVITY/ALLERGIES

Check all that apply. **Describe specific items.**

Sensitivity to sun: _____ Yes _____ No ____________________________________

Sensitivity to food: _____ Yes _____ No ____________________________________

Sensitivity to drugs: _____ Yes _____ No ____________________________________

Allergies: _____ Yes _____ No ____________________________________

Pertinent allergies in family: _____ Yes _____ No ____________________________________

FAMILY HISTORY OF ILLNESS/DISEASES

Describe the pertinent history, if any, or attach social history documentation: ______________________

____

____

____

____

____

HOSPITALIZATION RECORD

Please list known hospitalizations within the last five years.

DATE	PURPOSE

FINANCIAL/BILLING INFORMATION

Provider Service Billings should be submitted to:

_____ MA _____ County _____ Medical Assistance _____ CDCS _____ Private Pay

County of Financial Responsibility: ____

MA Identification Number: ____

Admission Service Agreement #: ____

Other – Specify: ____

Representative Payee: ________________________ Phone/Fax Number: ____________________________

Address: ____ E-mail: ___________________________

Does this individual have an additional Case Manager: _____ yes _____ no **(if yes, fill out the following)**

Additional Case Manager/Agency: ____

Phone/Fax Number: _______________________________ E-mail: __________________________________

Address: _____________________________ _____________________ ______________ _________

Street City State Zip Code

LEGAL GUARDIAN

Primary Guardian: _____________________________ _____________________ ____________________

Last First Middle

Relationship: ________________ __________________________ ________________ _______________

E-Mail Home Phone Cell Phone

Address: ______________________________ ____________________ _________ _____________

Street City State Zip

Secondary Guardian: __________________________ _________________________ _______________

Last First Middle

Relationship: ________________ __________________________ ________________ _______________

E-Mail Home Phone Cell Phone

Address: ______________________________ ____________________ _________ _____________

Street City State Zip

FAMILY CONTACTS

Father's Name: _________________________________ _________________________ ______________

Last First Middle

Address: ______________________________ ____________________ _________ _____________

Street City State Zip

Mother's Name: _________________________________ _________________________ ______________

Last First Middle

Address: ______________________________ ____________________ _________ _____________
Street City State Zip

Primary Family Contact: ____

Relationship: ________________ _________________________ ________________ _______________
E-Mail Home Phone Cell Phone

Address: ______________________________ ____________________ _________ _____________
Street City State Zip

FAMILY INVOLVEMENT

_____ Visits Regularly
_____ Visits Seldom
_____ Programmatic Interest
_____ Holiday Visits

_____ Unknown
_____ No Known Relatives
_____ Other

Physician preference:

Name:____
Address:_____________________________________
Phone:_______________________________________

Hospital preference:

Name:____
Address:_____________________________________
Phone:_______________________________________

Medical Release

In case of emergency and I cannot be reached, I hereby give permission for
____________________________________to be taken to a medical facility.
Date:______________________________Parent or Guardian:____________________________________

APPLICANT'S VOCATIONAL HISTORY

Have you ever been employed? ___________ Sheltered____________Competitive___________
Please list name of vocational agency or employer:
Agency:__________________________________From________________To__________________
Address:____
Street number City State Zip
Job responsibilities:____
Reason for leaving:____

Agency:____

Address:____
Street number City State Zip
Job responsibilities:____
Reason for leaving:____

Agency:________________________________From__________________To__________________
Address:____
Street number City State Zip
Job responsibilities:____
Reason for leaving:____

Name of Department of Vocational Rehabilitation Counselor (if any):
____

Address:____
Street number City State Zip
Telephone number:______________________________
Email:____

BEHAVIOR INFORMATION

	Check if Yes	Comments
1.Exhibits self-injurious behavior?	___________	____
2.Exhibits aggressive behavior?	___________	____
3.Destroys property?	___________	____
4.Exhibits verbally abusive behavior?	___________	____
5.Threatens others?	___________	____
6.Steals?	___________	____
7.Rummages in others possessions?	___________	____
8.Strips/exposes self?	___________	____
9.Eating disorder?	___________	____
10.Socially isolated?	___________	____
11.Exhibits irritating behaviors which could cause risk of retaliation?	___________	____
12.Needs assistance to settle disagreements?	___________	____

Other comments:
____
____
____
____
____

COMMUNICATION

	Consistently	Sometimes	Never	Comments
1. Turns eyes and head towards others who are speaking?				
2.Listens at least momentarily when spoken to by staff?				
3.Communicates with signs or gestures?				
4.Follows instructions requiring an object and a word?				
5.Says at least 50 recognizable words?				
6.Prints or writes own first and last name?				
7.States telephone number when asked?				
8.States complete home address including city and state?				
9.Talks on the telephone?				

SOCIALIZATION SKILLS

	Consistently	Sometimes	Never	Comments
1.Responds appropriately when introduced to strangers?				
2.Responds to hints or indirect cues in a conversation?				
3.Initiates conversation on topics of particular interest to others?				
4.Responds to hints of indirect comments in a conversation?				
5.Makes and keeps appointments?				
6.Goes to non-facility events with friends without supervision?				
7.Goes to social events in public where many individuals are present?				
8.Uses public transportation?				

DAILY LIVING SKILLS

	Consistently	Sometimes	Never	Comments
1.Helps with chores?				
2.Dresses in anticipation of changes in weather without being reminded?				
3.Looks both ways before crossing street/road?				
4.Demonstrates understanding of the				

function of money?				
5.Can inform staff of health related illnesses/injury?				

NON-DISCRIMINATION STATEMENT

Rules for acceptance and participation in the STEP program are the same for all individuals without regard to race, color, creed, national origin, age, gender or disability.

DATE:______________________________Parent or Guardian_______________________________________

RELEASE OF INFORMATION

I hereby authorize any physician, school, clinic, hospital, county nurse, Todd County Social Services, or court to release information regarding the applicant to STEP.

DATE:______________________________Parent or Guardian_______________________________________

Witness____

DATA PRIVACY NOTIFICATION

The Minnesota Data Privacy Act (Minnesota Laws 1975, Chapter 401) requires that we inform you that the information we have asked you to provide is necessary for effective administration of the services for which you are applying. The collection of this information is required by federal regulation, state law and/or Department of Human Services rules and regulations. Failure to provide this information could make you ineligible for the services which you have requested. The information collected will only be used by authorized agency personnel. Use of this information for purposes other than explained herein will not be made without your prior written approval, unless law specifically authorizes such other use. You have a right to review any information which is maintained by this agency about you as provided for in Chapter 401.

Applicant:____Date:________________________
Signature
Parent or Guardian:____Date:________________________
Signature
Witness:____Date:________________________
Signature