

ST. ANGELE HEALTHCARE SERVICES, INC.

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Developmental Disability Non-Center-Based Day Support for Adults · Licensed by DBHDS

REFERRAL AND INTAKE FORM

Community Engagement · Community Coaching

Complete what you can and send the rest later — an incomplete form is better than a delayed one. Return by email to marcelius@stangelhealth.com. We will respond within two business days with a plain yes or no on capacity and a realistic start date. Our participation agreement allows us to accept a referral only where services can genuinely begin within 30 calendar days, so we will tell you early rather than late.

1. Who is making this referral

NAME OF PERSON REFERRING | ROLE / TITLE

AGENCY OR CSB | RELATIONSHIP TO THE INDIVIDUAL

TELEPHONE | EMAIL | DATE OF REFERRAL

2. The individual

FULL NAME | DATE OF BIRTH | PREFERRED NAME

HOME ADDRESS | COUNTY OR CITY

TELEPHONE | MEDICAID ID | WAMS / ID NUMBER

PRIMARY LANGUAGE | INTERPRETER NEEDED? | GENDER

Waiver:

☐ Community Living
☐ Building Independence
☐ Family and Individual Supports
☐ Not yet enrolled / unsure

3. Where they live

We need the address we would collect from and return to.

Type of residence:

- ☐ Family home — lives with parents or relatives
- ☐ Sponsored or host home
- ☐ Own apartment or house, no residential supports
- ☐ Group home — licensed residential provider
- ☐ Own apartment or house, with supports
- ☐ Other

HOME ADDRESS — STREET, CITY, STATE, ZIP

If they live in a group home, please also give the house details. We coordinate pick-up, drop-off and daily communication with the staff there.

GROUP HOME OR PROVIDER NAME

HOUSE MANAGER OR CONTACT PERSON

GROUP HOME TELEPHONE

GROUP HOME EMAIL

4. Parent, guardian or authorized representative

Who we contact about this person. Leave blank if the individual makes their own decisions and prefers we deal with them directly.

NAME

RELATIONSHIP

TELEPHONE

EMAIL

HOME ADDRESS, IF DIFFERENT FROM THE INDIVIDUAL'S

Type of authority:

- ☐ Legal guardian
- ☐ Power of attorney
- ☐ The individual makes their own decisions
- ☐ Authorized representative
- ☐ Parent, no formal authority

5. Service requested

- ☐ Community Engagement — small group, up to three people
- ☐ Community Coaching — one to one

HOURS PER WEEK SOUGHT | DAYS OF THE WEEK | PREFERRED START DATE

PREFERRED TIMES OF DAY | PICK-UP LOCATION, IF NOT THE HOME ADDRESS

Transportation:

- ☐ Provider transportation needed
- ☐ Family provides transportation
- ☐ Uses public transport independently
- ☐ Uses public transport with support

6. Plan and authorization

- ☐ Individual Support Plan is current
- ☐ ISP is in development or under review
- ☐ Part V Plan for Supports available
- ☐ Service authorization already entered in WaMS

ISP DATE | ANNUAL REVIEW DUE | SUPPORT COORDINATOR

7. Support needs

Tick anything that applies. Detail goes in section 7.

- ☐ Personal care
- ☐ Mobility or transfers
- ☐ Communication support
- ☐ Medication administration
- ☐ Seizure disorder
- ☐ Diabetes
- ☐ Allergies
- ☐ Dietary or swallowing needs
- ☐ Behavioral support plan in place
- ☐ History of elopement
- ☐ Aggression toward others
- ☐ Self-injurious behavior
- ☐ Vision impairment
- ☐ Hearing impairment
- ☐ Uses a wheelchair
- ☐ Requires two-person support

ANY RESTRICTIVE TECHNIQUES AUTHORIZED IN THE PLAN? | NURSING OVERSIGHT OR DELEGATION REQUIRED?

8. Doctors

Who we would contact in a health emergency, and who manages any psychiatric medication. Give what you have — we do not need records at this stage.

Primary care physician

NAME | PRACTICE OR CLINIC

TELEPHONE | ADDRESS OR CITY

Psychiatrist or behavioral health prescriber, if there is one

NAME | PRACTICE OR CLINIC

TELEPHONE | ADDRESS OR CITY | SEEN HOW OFTEN

9. What a good week looks like for this person

The most useful part of this form. What do they enjoy, what are they working toward, what should staff know on day one, and what does a bad day look like?

10. Other providers and services

RESIDENTIAL PROVIDER, IF ANY | OTHER DAY OR EMPLOYMENT SERVICES

REASON FOR SEEKING A NEW DAY SUPPORT PROVIDER | PREVIOUS PROVIDER, IF ANY

11. Documents to send with this form

None of these stop us responding. Send what you have.

- ☐ Individual Support Plan
- ☐ VIDES or level of care documentation
- ☐ Current medication list or MAR
- ☐ Guardianship or authorized representative papers
- ☐ Part V Plan for Supports
- ☐ Behavioral support plan
- ☐ Medical orders or care plan
- ☐ Emergency contact sheet

Office use only

DATE RECEIVED	RECEIVED BY	ACKNOWLEDGED ON
CAN WE START WITHIN 30 DAYS?	STAFFING AVAILABLE?	CAPACITY DECISION
DECISION COMMUNICATED TO	DATE COMMUNICATED	
IF DECLINED, REASON GIVEN		

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