# FISCAL INTERMEDIARY REFERRAL FORM

## 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 below 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 #<br>TABS ID # | Race and/or Ethnicity: |
| Current living arrangement:<br>☐ Independent/Alone<br>☐ With Family or Friends | | ☐ Certified Setting<br>If selected, specify operating agency: |

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: _____

What is the projected start date of budget/services? _____

| **Who is the individual's guardian?** | | |
|---|---|---|
| Self: ☐ | Parent(s) or Family: ☐<br>Name(s): | Other: ☐<br>Name(s): |

| **Guardian Name(s):** | |
|---|---|
| Relation to individual: | |
| Current address (if different from individual's): | |
| Current phone #: | Current email: |

| **Emergency Contact Name(s):** | |
|---|---|
| Relation to individual: | |
| Current address: | |
| Current phone #: | Current email: |

| **Care Coordinator Name:** | |
|---|---|
| Agency: | |
| Agency address: | |
| Phone #: | Email: |

| **Broker Name:** | |
|---|---|
| Agency: | |
| Agency address: | |
| Phone #: | Email: |

| **Other Direct Service Provider(s):** | |
|---|---|
| **Name, Address, Phone, Email** | **Services provided** |
| | |
| | |
| | |

| **Current Representative Payee Name:** | |
|---|---|
| Relationship to individual: | |
| Address: | |
| Phone #: | Email: |

| **Other Involved Natural Supports:** | |
|---|---|
| | |
| | |
| | |

**What services is the individual requesting in their budget? Please check all that apply:**

| | | | | |
|---|---|---|---|---|
| ☐ FI | ☐ Broker | ☐ CH Self-Hire | ☐ Respite Self-Hire | ☐ Live-in Caregiver |
| ☐ Paid Neighbor | ☐ IDGS | ☐ OTPS | ☐ FRR | |
| ☐ Direct provider purchase | | Please specify what service: | | |

PLEASE NOTE:

- At this time, Starbridge does not provide support for these services: SEMP Self-hire, Live in Caregiver.
- To best serve you and ensure we have access to all charts/records pertaining to your services, Starbridge participates in all ISP meetings via phone.

## 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)
☐ 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: