Step By Step
Supportive Services

Please send completed forms to:
Step By Step Attn: Intake
1470 Beacon Street, Suite B, Brookline, MA 02446
617-277-6140 (P) 617-277-0168 (F)
Please call or e-mail referralinfo@stepbystepss.org
With any additional questions

Referral Checklist

Our comprehensive referral process assures that each client accepted into Step by Step Supportive Services has the maximum potential for success. The following items will need to be received before SBS can make an individual determination. The length of the referral process varies based on how long it takes to obtain the forms and records.

- ☐ Client Application Form A
- ☐ Family History Form B
- ☐ Clinician Form C
- ☐ Signed Authorized Disclosure Forms for Hospitals, Treatment/Residential Facilities, Psychiatrist, Therapist, guardian/parents
- ☐ Pertinent Medical and Psychiatric Records (including hospitalizations within past 3 years)
- ☐ Treatment Records and Communication from Providers
- ☐ Records from Previous Treatment/Residential Facilities

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Client Application

The applicant or legal guardian should fill out this form to the best of their ability. Please attach additional pages if necessary.

Please indicate which of the following services you are applying for:

Step by Step Residential Living:
1470 Beacon Street

Step by Step Community Based Services
___ Full Care Package
___ Case Management
___ Wellness Program
___ Groups
___Saturday Activities

SECTION ONE: GENERAL INFORMATION

Applicant's Name: _____

Address: _____City_____ State___ Zip Code_____

Email: _____

Cell #:_____

Date of birth: _____ Gender/preferred pronouns:_____

Social Security #:_____

Race/Ethnicity: _____Religion/Spirituality: _____

Do you have a court appointed legal guardian? ___ Yes ___ No (please provide paperwork)

Name of legal guardian: _____Relationship:_____

Telephone #: _____

Emergency contact person: _____

Phone: _____

Health insurance provider: _____Name of Policy Holder: _____

Policy and Plan information: _____

SECTION TWO: GETTING TO KNOW YOU

What are you hoping to achieve with the support of Step by Step? How can Step by Step help you?

What are some of your strengths and important happenings in your life?

What is currently holding you back from achieving your goals?

How would you like your life to look in the future?

Do you have any cognitive, physical or psychiatric diagnosis? If so, please list

How do your disabilities impact your life?

Can you make your needs known during a program? ___ Yes ___ No

Are you comfortable in the outdoors? ___ Yes ___ No
Are you comfortable being in and around water? ___ Yes ___ No
Are you comfortable being in crowds? ___ Yes ___ No
Are you able to use public transportation independently? ___ Yes ___ No
Are you independent with activities of daily living? (i.e toileting, bathing, etc.) ___ Yes ___ No
Will you be able to refrain from behaviors that pose a risk to yourself and/or others? __ Yes ___ No
If answering no to any of the above, please explain: _____

_____

_____

Have you ever been arrested? ___ Yes ___ No
Have you ever been convicted of a crime? ___ Yes ___ No
Do you have any ongoing legal matters? ___ Yes ___ No
If answering yes, please explain: _____

_____

_____

SECTION 3: MEDICAL INFORMATION AND HISTORY

Please attach a list of your current medications to this application

Are you able to take these medications independently and without a reminder? ___ Yes ___ No
Do you experience any significant side effects? _____
Please list any allergies and/or dietary restrictions (including medicines, food, bites, stings, etc.):

_____

_____

_____

Please list your current medical and psychiatric providers: Date of last physical exam: _____

PCP: Phone: _____

Therapist: Phone: _____

Psychiatrist: Phone: _____

Other: _____

Do you plan to continue work with these providers upon acceptance into SBS? ___ Yes ___ No

Are you currently facing any medical conditions, acute or chronic? If so please describe below and include:
• What specific symptoms are occurring • How long symptom/condition lasts and how often
• Date of last occurrence • How you care for symptom/condition • How symptom/condition restricts you

Condition/Detailed Description

_____

_____

Do you have a history of self-injurious behaviors? ___ Yes ___ No
Do you have a significant history of suicidal ideation? ___ Yes ___ No
Have you ever attempted suicide before? ___ Yes ___ No
Do you currently use any substances? ___ Yes ___ No Date of last use: _____
Has there ever been a history of alcohol abuse? ___ Yes ___ No
Has there been a history of drug use? ___ Yes ___ No
Have you ever sought substance abuse treatment? ___ Yes ___ No
If answering yes to any of the above, please further describe: _____

Have you ever been hospitalized for medical or psychiatric purposes? ___ Yes ___ No

Please list hospitalizations and residential or treatment placements within past 3 years, include date, reason for admission, diagnosis, etc.

Please attach discharge summaries to this application

Hospital/Placement	Dates	Reason for Leaving

Signature: _____ Date: _____

Print name: _____

Did someone help you complete this form? ___ Yes ___ No Name:_____
How did he/she help you?_____