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
- ☐ Pertinent Medical and Psychiatric Records (including hospitalizations within past 5 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
___ Vocational Services
___ Evening Groups

Step by Step Adventures
___Saturday Activities
___Overnight Trips

SECTION ONE: GENERAL INFORMATION

Applicant's Name: _____
Address: _____
Email: _____
Telephone #: _____Cell #:_____
Date of birth: _____ Gender:_____
Social Security #:_____

Race/Ethnicity: _____
Religion/Spirituality: _____
Preferred Language: _____
Are you literate in your native language? ___ Yes ___ No
Do you speak English? ___ Yes ___ No Are you literate in English? ___ Yes ___ No

Do you have a court appointed legal guardian? Yes No
Name of legal guardian: _____
Relationship to you: _____
Telephone #: _____

Emergency contact person: _____
Phone: _____

Health insurance provider: _____
Plan: _____ Name of Policy Holder: _____
Policy # _____

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 TWO: GETTING TO KNOW YOU

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

How do your disabilities impact your life?

Please write about some of the important happenings in your life.

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?

What is currently holding you back from achieving your goals?

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

SECTION 3: MEDICAL INFORMATION AND HISTORY

Medications – List any medications you are using (include over the counter)

Medication	**Condition**	**Dosage (size and frequency)**	**Prescriber**

Are you able to take these medications independently and without a reminder? ___ Yes ___ No

Any significant side effects?

Allergies and dietary restrictions (including medicines, food, bites, stings, etc.):

Allergy	**Reaction**	**Do you carry meds? If so, what?**

Please list your current medical and psychiatric providers:

PCP: Phone:

Therapist: Phone:

Psychiatrist: Phone:

Dentist: Phone:

Other:

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

Date of last physical exam: _____

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
If answering yes to any of the above, please further describe: _____

Do you currently use any substances? ___ Yes ___ No
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
Date of last use: _____

Have you ever been hospitalized for medical or psychiatric purposes? ___ Yes ___ No
Please list hospitalizations within past 10 years, include dates, reason for admission, diagnosis, etc.

Please attach discharge summaries to this application

_____

_____

_____

_____

_____

_____

Please list any other residential and/or treatment programs you have been to.

Program **Dates** **Reason for leaving**

_____

_____

_____

_____

_____

Signature: _____ Date: _____

Print name: _____

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

_____