State of Illinois
Department of Human Services - Division of Developmental Disabilities

SUPPORT SERVICES TEAMS REFERRAL FORM

SST Receiving Referral | **County of Person's Residence** | **Date of Referral** | **Time of Referral**

Last Name of Person Referred | **First Name of Person Referred** | **Birth Date** | **Age** | **Sex**

Race/Ethnicity | **SSN** | **RIN** | **Medicare Number, if known**

Insert a narrative describing what the person/provider hopes to achieve from receiving SST Services:

What is one goal that the SST can help the individual achieve?

Current and History of Supports:

Check and underline all that apply

- ☐ 56 U - Behavior Intervention and Treatment
  - ☐ Current ☐ History
- ☐ 57 U - Individual Counseling
  - ☐ Current ☐ History
- ☐ 58 U - Individual Psychotherapy
  - ☐ Current ☐ History
- ☐ 52 P - Physical Therapy
  - ☐ Current ☐ History
- ☐ 52 O - Occupational Therapy
  - ☐ Current ☐ History
- ☐ 52 S - Speech Therapy
  - ☐ Current ☐ History
- ☐ 53 C - Temporary Assistance
  - ☐ Current ☐ History
- ☐ 37 U - At home Day Program
  - ☐ Current ☐ History
- ☐ 53 R - Residential Initial Staffing
  - ☐ Current ☐ History
- ☐ 53 R - Residential Long-term Staffing
  - ☐ Current ☐ History
- ☐ 53 D - CDS Initial Staffing
  - ☐ Current ☐ History
- ☐ 53 D - CDS Long-term Staffing
  - ☐ Current ☐ History
- ☐ 31 A - Developmental Training
  - ☐ Current ☐ History
- ☐ 31 U - Developmental Training
  - ☐ Current ☐ History
- ☐ 35 U - Adult Day Care
  - ☐ Current ☐ History
- ☐ 36 U - Supported Employment
  - ☐ Current ☐ History
- ☐ 36/33 G U - Supported Employment
  - ☐ Current ☐ History

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Type of Living Arrangement | Current Funding Source | Provider FEIN

Full Address of Current Residence | How long at this residence, if known

Where is the Person Right Now? | Person's Communication Method | Person's Primary Language

Provider Name | Provider Address

Executive Director Name | Executive Director Phone Number | Executive Director Email Address

Provider Contact Name | Provider Contact Phone Number | Provider Contact Email Address

PAS/ISC/ISSA Agency Name | Contact Name | Contact Phone Number

Guardianship Type | Guardianship Relation | Guardian Consent for SST

Guardian Name and Contact Information

Name and Contact information of Family Contact (if different from the Guardian listed above)

DDD Bureau of Community Services' Region | Referring DDD Staff Name and Phone Number

Reason for Referral | Frequency | Severity

Reason for Referral | Frequency | Severity

Reason for Referral | Frequency | Severity

Reason for Referral | Frequency | Severity

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Insert person's current full diagnosis, a brief narrative describing the person being referred and the reason for referral:

Describe when change in behavior was first observed and how it was responded to/addressed:

List any and all adaptive equipment utilized by the person being referred: