Southern Tier Independence Center
Family Support Services Behavior Support

The Southern Tier Independence Center's Family Support Services Behavior Support program serves families in Broome, Tioga, and Chenango counties. Referrals can be submitted by Care Managers and/or family members.

To be eligible for this service the individual must meet the flowing criteria:

- Be OPWDD eligible.
  - If eligibility is needed, families/guardians should contact OPWDD Front Door at 607-240-4900.
- At least 3 years old
- Have a DDP2 behavior score of 50 or higher.
- Live with a family member

When completing this referral please send along the following documents:

- LCED within 1 year of the date of the referral
- Documentation of disability is a **clinical assessment** substantiating a specific diagnosis of developmental disability. It may include, but is not limited to:
  - A psychological evaluation including I.Q. score documenting the individual's developmental disability.
  - A psychosocial evaluation documenting the individual's developmental disability.
  - Medical documentation indicating the individual's developmental disability.
- IEP/School evaluations (**for school age individuals only**)
- DDP2 with scores (**must be within two years of the referral date**)
- Life Plan
- Notice of Decision
- Release of Information

If you have any questions, please contact Director of Behavioral Services at (607) 724-2111 or via e-mail. The attached referral form is a fillable document. Please return the completed referral and accompanying documents to behavior@stic-cil.org. If you need to mail this referral packet, please send to:

Director of Behavioral Services
Southern Tier Independence Center
135 E Frederick Street
Binghamton, NY 13904

Southern Tier Independence Center
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Referral Form

Date Submitted:

Child's Name:

Child's DOB:

Guardianship:

Diagnosis:

Check all that apply

☐ **Autism**	☐ **ADD/ADHD**	☐ **ODD**
☐ **Impulse Control Disorder**	☐ **Down Syndrome**	☐ **OCD**
☐ **Cerebral Palsy**	☐ **Fetal Alcohol Syndrome**	☐ **Bi-Polar disorder**
☐ **PTSD / C-PTSD**	☐ **Epilepsy / Seizure Disorder**	☐ **Schizophrenia**
☐ **Gastro-Intestinal**	☐ **Sleep Disorder / Disturbance**	☐ **Anxiety Disorder**

Other Medical:

Other Neurological: ☐ **Yes** ☐ **No** **If yes, what:**

Respiratory: ☐ **Yes** ☐ **No** **If yes, what:**

Cardiovascular: ☐ **Yes** ☐ **No** **If yes, what:**

Parents' Name(s):

Phone Number: **Email Address:**

Address:

School District:

Name/Address of school:

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Name of Care Manager (CM)/Care Coordination Organization:

CM phone number/email address:

Medicaid #: **Tabs ID:** **Tier:** ☐ 1 ☐ 2 ☐ 3 ☐ 4

DDP2 Behavior score: **(Must be 50 or higher)**

Please be clear and specific about the behaviors that prompted the need for this referral and how it is impacting the individual and their family.

Reason for referral:

Additional services / programs individual is receiving :

Is the individual Self- Directing: ☐ **Yes** ☐ **No**

If yes, is Family Support Services in their budget? If y ☐ **Yes** ☐ **No**

how many # of hours have been approved?

Broker Name/Phone/Email:

FI Name/Phone/Email: