D·B·H·D·D

Office of Supportive Housing
Crisis Respite Apartment (CRA) Referral Form

Referral Checklist

Please be sure to attach all the below requested supporting documentation in the red boxes or the referral will not be considered complete.

- ☐ **Birth Certificate**
- ☐ **Social Security Card**
- ☐ **ID Card**
- ☐ **30 day Medication Administration Record (MAR)**
- ☐ **Individualized Recovery Plan (IRP)**
- ☐ **Biopsychosocial Assessment (BPS)**
- ☐ **Psychiatric Evaluation**
- ☐ **30 days of progress notes**
- ☐ **Functional Assessment**
- ☐ **Probate Order or Conditional Release Plan**
- ☐ **Guardianship or Power of Attorney Documents**

Date Referral Completed and Submitted by Referral Source:

(For Use By Receiving Provider Agency Only)

Date Referral Received: Received By:

Initial Referral Status (within 3 business days of receipt): ☐ Complete ☐ Incomplete

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Staff Person Making Decision:

Referral Decision: ☐ Pending ☐ Approved ☐ Denied

Utilize the below section for any applicable comments, status updates, and/or final dispositions:

Office of Supportive Housing
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Clear Form

Please Select a Region: Select Region Please Select a Referral Type: Select Referral Type

Referring Agency: _____

Name and Title of Person Completing Referral: _____

Email Address: _____ Phone: _____

1. Basic Information:

First Name: _____ M.I.: _____ Last Name: _____

Date of Birth: _____Race/Ethnicity: _____SSN#: _____

Gender: _____ Marital Status: _____

Phone number where individual can be reached: _____

Best time to be reached? _____

Residential Address: _____ County: _____

City: _____ State: _____ Zip Code: _____

Emergency Contact Name: _____ Relationship: _____

Phone (Day): _____ Evening: _____

2. Psychiatric History:

Disability: MH ☐ I/DD ☐ SA ☐

Diagnosis:

3. Additional Diagnosis (To include any medical diagnosis):

A. _____ E. _____

B. _____ F. _____

C. _____ G. _____

D. _____ H. _____

E. _____ J. _____

4. List of current medications, dosages, and frequency (To include any medical medications): Please **DO NOT** write *"SEE ATTACHED".* Medications must be handwritten. Add additional pages as necessary.

A. _____ F. _____

B. _____ G. _____

C. _____ H. _____

D. _____ I. _____

E. _____ J. _____

If individual receives a long-acting injection (LAI), Date of last injection: _____

Any PRN medications in the last 30 days? Yes ☐ No ☐ Describe _____

5. Immunization History

Date of last PPD: _____ Results: Positive ☐ Negative ☐

Date of 1st COVID Immunization: _____

Date of 2nd COVID Immunization: _____

Booster: Yes ☐ No ☐ Date Administered: _____

6. Community Care Provider Involvement:

Active ☐ Inactive ☐

Community Provider: _____ ADA Service: _____

Primary Contact: _____Phone: _____Email: _____

7. Admission Criteria (Check all that apply):

A. Individuals with a severe and persistent mental illness that require a short-term supportive environment to prevent reoccurrence of one or more of the following problems:

☐ Transitioning or recently discharged from a psychiatric inpatient setting

☐ Frequently admitted to a psychiatric inpatient facility or crisis stabilization unit (i.e. three or more admissions within the past 12 months or extended hospitalization stay of 60 days within the past 12 months)

☐ Chronically homeless (i.e. one extended episode of homelessness for one year, or four episodes of homelessness within three years)

☐ Recently released from jail or prison

☐ Frequently seen in emergency rooms for behavioral health needs (i.e. three or more visits within past twelve months)

☐ Currently being served by a Coordinated Specialty Care for First Episode Psychosis team

B. Individual can live independently with minimal supervision as evidenced by all the following:

☐ Individual is free of medical issues that require daily nursing or physician care

☐ Individual does not demonstrate danger to self or others and is able to safely remain in an open community-based placement

☐ Individual can live independently and only require minimal support with strengthening already acquired independent living skills

C. Individual has a clear housing goal and can be transitioned within the below time frame:

☐ 30 – 90 days ☐ 91 - 120 days

D. Individual has some functional impairments and could benefit from:

☐ One face to face contact daily ☐ Three face to face contacts daily

☐ Several hours of skill building

E. Individuals discharging from a State Hospital with an approved Notice to Proceed (attach NTP).
Note: This is not a requirement of admission; however, it does indicate priority admission.

8. Behavioral Concerns/Psychosocial Stressors/Events (Check all that apply):

☐ Suicidal		☐ Homicidal	
☐ Elopement Risk		☐ History of Fire Setting/Arson	
☐ Eviction		☐ Homelessness	
☐ Legal Issues		☐ Financial Difficulties	
☐ Sex Offender		☐ Relapse/De-compensation	
☐ Hearing Impaired		☐ ADA accessibility/accommodations	
☐ Abuse (Select all that apply)	☐ Physical	☐ Sexual	☐ Emotional
☐ Aggression (Select all that apply)	☐ Physical	☐ Sexual	☐ Emotional

Other (Please Describe): _____

Provide explanation for items checked abpve:

9. Residential History

A. Where has the individual previously resided?

☐	Homeless	☐	With Friends and/or Family
☐	Personal Care Home	☐	Independently
☐	Substance Abuse Treatment Facility	☐	In a DBHDD funded Residential Program

Please provide a brief description of any disruptions of items selected above:

B. Is the individual capable of independent living. Please be very detailed in your response.

C. Please be sure to attach a copy of the most recent Functional Assessment for review.

10. Legal History: (Please attach any Court Orders as indicated)

A. Outpatient Mandate: Yes ☐ No ☐ Expiration Date: _____

Conditions:

B. Forensic Conditional Release: Yes ☐ No ☐ FCC Name: _____

Current Charges:

C. Has the individual been referred for CIH placement? Yes ☐ No ☐

Current referral status:

D. Probation/Parole Officer Name: _____ Phone Number: _____
Email: _____
Conditions of Probation/Parole:

E. Is there a required level of supervision? Yes ☐ No ☐
Explain circumstances:

F. Pending charges/Court hearings: Yes ☐ No ☐ Date: _____
Pending Charges:

11. Financial History / Health Insurance:

A. Amount(s) (Check all that apply)

☐ SSI Monthly Amount: $ ☐ SSDI Monthly Amount: $

☐ VA Monthly Amount:$ ☐ Other Monthly Amount: $

Source:

B. Health Insurance (Check all that apply)

☐ Medicaid ID# ☐ Medicare ID#:

☐ Health Insurance Subscriber Company:

Policy Number: Policy Holder:

C. Representative Payee or Fiduciary: Yes ☐ No ☐

Name Telephone Number:

Address:

D. Guardian: Yes ☐ No ☐ Type:

Name: Telephone Number:

Address:

12. Employment History:

Employed: Yes ☐ No ☐ If no, date of last employment:

Name of Company: Length of Employment:

Address of Company: