Office of Supportive Housing
Community Residential Rehabilitation (CRR) Level 1, 2 & Level 3 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

Community Residential Rehabilitation (CRR) Level 1, 2 & Level 3 Referral Form

Clear Form

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

*** NOTE: CRR Level 1 Referrals go directly to the Regional Field Office***

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 ☐ SUD ☐

Diagnosis:

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

A. _____ F. _____

B. _____ G. _____

C. _____ H. _____

D. _____ I. _____

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 aged 18 and older with a primary severe and persistent mental illness with *significant functional impairments* that severely impair their ability to live in a community-based setting without a high level of residential support and supervision as evidenced by needing assistance with the following:

☐ Maintaining hygiene ☐ Selecting proper clothing

☐ Meeting nutritional needs ☐ Avoiding common dangers/hazards

☐ Caring for personal business affairs ☐ Engaging in medical/dental care

☐ Maintaining medication compliance ☐ Self-administering medications

☐ Failure to perform daily tasks ☐ Carry out household responsibilities

☐ Social isolation/no family support ☐ Substance use/co-occurring

B. There is a need for 24/7 staff support to ensure safety and harm reduction to self and others:

☐ AWAKE, and on site at all times ☐ On site at all times ☐ Not on site at all times

C. Individual with two or more of the following indicators of continuous high service needs:

☐ High use of psychiatric hospital or crisis stabilization unit

☐ Persistent symptoms that place individual at risk of harm to self or others

☐ Co-existing substance use of significant duration

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

D. Individual recently transitioning from:

☐ State psychiatric hospital ☐ CSU/BHCC ☐ Homelessness ☐ Jail

☐ CRR Level I ☐ CRR Level II ☐ CRR Level III

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

☐ Suicidal		☐ Homicidal	
☐ Elopement Risk		☐ Sleep Disturbance	
☐ Poor Impulse Control		☐ Poor Safety Judgment	
☐ History of Fire Setting/Arson		☐ Legal Issues	
☐ Financial Difficulties		☐ 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 below:

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 explanation of any disruptions of items checked 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 ☐
If Yes, 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: