**OUT OF CATCHMENT REFERRAL INSTRUCTIONS**

The out of catchment referral is to be used when individuals are being discharged from the state hospital to a catchment area that is outside of the originating CSB’s area. The form is utilized to provide information about the individual, as a referral for needed services, and notification for emergency services.

The form has two parts: notification and referral.

For individuals residing short term in another catchment area, or individuals not engaged in CSB services:

* **Please complete page 1- Notification-** This page provides necessary information for CSBs to be aware of individuals discharging from state facilities who are temporarily in another catchment area, or individuals discharging to a catchment area that will not be referred to CSB services.

For individuals being placed in another catchment who will require CSB services AND/OR have a DAP plan for services in another catchment area:

* **Please complete the entire referral form**
* **Please provide documentation including any EHR face sheet and most recent assessments. Additionally, at discharge, please provide the hospital discharge information to the accepting CSB.**

**If the individual has a DAP plan, please be sure to submit the narrative and IDAPP to the accepting CSB and the regional manager.**

**OUT OF CATCHMENT NOTIFICATION/REFERRAL FORM**

Notification Only *(Page 1)* Full Referral **(***Pages 1-3; for individuals who will be referred for services)*

Patient Name:

Last 4 of SS#:      DOB: Click or tap to enter a date.

State Hospital: Choose an item.

Admission Date: Click or tap to enter a date.

Primary Diagnosis:

Anticipated Discharge Date: Click or tap to enter a date. Next Treatment Team Date:Click or tap to enter a date.

Social Worker:       Phone Number:Click or tap here to enter text.

Current CSB: Choose an item.

Name of Contact:

|  |  |
| --- | --- |
| Phone: | Email: |

CSB of Discharge Residence: Choose an item.

Name of Contact:

|  |  |
| --- | --- |
| Phone: | Email: |

Discharge Address:

Type of Residence:

Phone Number:

Contact at Residence (if applicable):

Does this individual have a legal guardian or POA? Choose an item.

(If yes, please list below under “Emergency Contact”)

Emergency contact:

Address:

Phone:

Does this individual have a conservator or payee? Choose an item.

Name:

Address:

Phone:

Will this individual be referred for any services at CSB of discharge residence? Choose an item.

***(If yes, please complete the remaining pages of this form.)***

1. **Previous Housing** – Please list the individual’s housing prior to admission to the state hospital:

Type of Housing:

Name of Residence (if applicable):

Reason Not Returning:

1. **Entitlements and Funding Sources**

SSI/SSA Amount:

SSDI Amount:

Medicaid List # and Type:

Medicare List # and Type:

DD Waiver Choose an item.

Auxiliary Grant Local DSS office where application sent:

SNAP

VA Benefits Click or tap here to enter text.

Private Insurance List Type and #:

Other:

1. **DAP**

Type: Choose an item.

Reason Needed:

1. **Community Support** – What type of community-based services will be required?

Case Management

PACT/ICT

Mental Health Skill Building

Psychosocial Rehabilitation

Employment Services:

Substance Use Services:

Outpatient Services:

Other:

DAP Monitoring

1. **Legal Status**

Does individual have a valid ID? Choose an item.

Does the patient have any existing/pending criminal charges or court dates?Choose an item.

List Charges:

Court:

Court Date(s):

Is the individual NGRI? Choose an item. If yes please follow NGRI protocols.

1. **Safety and Support Plan/Crisis Plan Initiated?** - Choose an item.

*(If Yes, please attach)*

1. **Electronic Signature**

Notifying/Referring CSB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referral Sent to: Click or tap here to enter text.

Date: Click or tap to enter a date.

Referral Communication Method:Choose an item.