**Community Transitions Referral Form**

Please complete referral at [www.rmhumanservices.org/bh](http://www.rmhumanservices.org/bh).

For questions, please contact [CTReferrals@rmhumanservices.org](mailto:CTReferrals@rmhumanservices.org) or call 303-636-5635

This referral encompasses two programs, both of which are voluntary. Check all boxes for eligibility that apply. For TSP, one box must be checked in all three sections to meet criteria.

**Client/Guardian has agreed to this referral: Yes  No**

|  |  |
| --- | --- |
| **Momentum Program**  **Adult (21+)**  **Current inpatient psychiatric hospitalization** in an institute or acute hospital for one month or longer with significant barriers to discharge  **Current inpatient psychiatric hospitalization** with at least two prior inpatient psychiatric admissions at an approved hospital or ATU in the past 12 months  Defendants pleading “Not Guilty by Reason of Insanity” (NGRI) and **currently hospitalized**  Defendants deemed “Incompetent to Proceed” (ITP) and **currently hospitalized**  **(Western Slope clients only):** **Current psychiatric hospitalization** with a past history of psychiatric hospitalizations that resulted in barriers to discharge that have prohibited a successful transition into a home community  **Child/Adolescent (Age 20 and younger)**  Must have a current behavioral health diagnosis  **Current inpatient psychiatric hospitalization** lasting greater than 2 weeks  **Current inpatient** **psychiatric hospitalization** with at least two prior inpatient psychiatric admissions at an approved hospital or ATU in the past 12 months  C**urrent involvement** with 2 or more systems, such as juvenile justice, child welfare, school discipline, IEP and the youth is in need of transitional case management, services, and/or supports not funded by another source | **Transition Specialist Program**  **All Ages**   1. Receiving some orall of the following treatments**:**   **Currently** on a 72-hour hold  **Currently** on a certification for short-term treatment or extended short-term treatment  **Currently** on a certification for long-term treatments  **Currently** on an emergency commitment (substance use disorders)  **Currently** on an involuntary commitment (substance use disorders)   1. Has a significant mental health or substance use disorder, which means a history of:   **Two or more 72-hour holds** or emergency commitments in the last 12 months  **Certified for short-term treatment**, extended short-term treatment or long-term treatment at least 1 time in the last 12 months  **Arrested or detained** two or more times related to an alcohol or substance use disorder in the last 12 months and does not have a probation or parole officer   1. Is not currently engaged in consistent behavioral health treatment:   Has not received any behavioral health services (outside of the crisis services, emergency care, assessments, inpatient hospitalization, or emergency commitments at a withdrawal management center) in the last 45 days |

**Client Demographics**

**Client Legal Name:** Click or tap here to enter text.

**Date of Birth:** Click or tap here to enter text.

**Medicaid Number (If Applicable):** Click or tap here to enter text.

**Social Security Number:** Click or tap here to enter text.

**Gender**:  Female  Male  Transgender  Prefer to self-describe: Click or tap here to enter text.

**Ethnicity:** Click or tap here to enter text.

**Client Address:** Click or tap here to enter text.

**Client Phone Number:** Click or tap here to enter text.

**Name & Phone Number for Guardian/Emergency Contact (if Applicable):** Click or tap here to enter text.

**Current Living Situation**

Out of State  Host/Group Home  Regional Center  ACF  Nursing Home

Staying or Living w/family or friend  Residential (Youth)  Residential (SUD)  Foster Care

Emergency Shelter, including hotel/motel paid by 3rd party  Hotel/motel paid for w/out emergency shelter voucher

Jail, Prison, or Juvenile Detention Facility  Home owned by client  Rental by client with voucher

Rental by client, no ongoing subsidy  Homeless/place not meant for habitation (Car, streets, etc.)

Transitional Housing  Client doesn’t know  Client refused  Unknown  Other: Click or tap here to enter text.

**Referral Information**

**Referral Agency:** Click or tap here to enter text.

**Person Referring:** Click or tap here to enter text.

**Referral Email:** Click or tap here to enter text.

**Referral Phone Number:** Click or tap here to enter text.

**Current Behavioral Health Information**

**Behavioral Health and/or Substance Use Disorder Diagnoses (list all that apply):** Click or tap here to enter text.

**Other Diagnoses:** ­­­­­­­­­­­­Click or tap here to enter text.

**Current Physical Location of Client (Facility Name):** Click or tap here to enter text.

**Admission Date:** Click or tap here to enter text.

**Anticipated Discharge Date/Time:  ­­­­­­­­­­**Click or tap here to enter text.

**Assigned Social Worker/Case Manager:** Click or tap here to enter text.

**Social Worker/Case Manager Phone Number:** Click or tap here to enter text.

**Social Worker/Case Manager Email:** Click or tap here to enter text.

**Previous Hospitalization/Hold History within Past Year**

**Facility 1:** Click or tap here to enter text. **Facility 3:** Click or tap here to enter text.

**Admission Date 1:** Click or tap here to enter text. **Admission Date 3:**Click or tap here to enter text.

**Discharge Date 1:**Click or tap here to enter text. **Discharge Date 3:** Click or tap here to enter text.

**Facility 2:**Click or tap here to enter text. **Facility 4:** Click or tap here to enter text.

**Admission Date 2:** Click or tap here to enter text. **Admission Date 4:** Click or tap here to enter text.

**Discharge Date 2:** Click or tap here to enter text. **Discharge Date 4:** Click or tap here to enter text.

**Outpatient Behavioral Health Information**

**Community-Based Behavioral Health Provider:** Click or tap here to enter text.

**Phone Number and Email:** Click or tap here to enter text.

**Child/Adolescent (Under 21) System Involvement (check all that apply)**

Juvenile Justice  School Detention/Suspensions

Child Welfare  Other (Please list)

IEP

**How can Community Transitions be helpful for your client?**

Click or tap here to enter text.

**Additional Information if applicable such as housing plan, supports in the community, benefits applied for etc.**

Click or tap here to enter text.