Revision April 2020

SPH In-Reach/Transitions to Community Living Tool

This tool is to be started from the first contact with an individual during the In-Reach process and then follow that individual until they are successfully transitioned into the community or withdrawn from the TCL initiative.

Please fill in all areas completely and if information is not applicable put N/A.

SECTION A. DEMOGRAPHICS			
1. Participant Data			
First Name:		**Last Name:**	
Alpha ID#		**DOB:**	
Street Address:		**City,State,Zip**	
Phone:	#1	#2	

Medicaid County		**Medicaid #**		**County of Residence**	

2. Guardian/Authorized Rep Data			
Is there a Guardian/Rep?	Yes☐ No ☐ NA ☐		
If yes - relationship:			
First Name:		**Last Name**	
Street Address:		**City,State,Zip**	
Phone	#1	#2	
3. Emergency Contact Data:			
First Name		**Last Name**	
Street Address:		**City,State,Zip**	
Phone	#1	#2	

Other Friends/Family

Name	**Relationship**	**Address**	**Phone #1**	**Phone #2**

4. Payee Contact Data			
Payee	Yes☐ No ☐ NA ☐		
First Name		Last Name	
Phone	#1	#2	

SECTION B: **ONE PAGE PROFILE**
(SEE IN REACH/TRANSITIONS TO COMMUNITY LIVING CONVERSATIONAL GUIDANCE DOCUMENT)

SECTION C: **MY/OTHERS PERSPECTIVE** (OPTIONAL)
(SEE IN REACH/TRANSITIONS TO COMMUNITY LIVING CONVERSATIONAL GUIDANCE DOCUMENT)

SECTION D: **A GOOD WEEK OF MEANINGFUL DAYS** (OPTIONAL)
(SEE IN REACH/TRANSITIONS TO COMMUNITY LIVING CONVERSATIONAL GUIDANCE DOCUMENT)

SECTION E: MEDICAL AND MENTAL HEALTH INFORMATION (OPTIONAL)					
1.	**Medical Issue/Condition – Date Updated:**	**Medication Prescribed**	**Date of Onset**	**Doctor/Practice Treating Issue**	**Client Perception of Severity of Condition**
a.		☐ Yes ☐ No			
b.		☐ Yes ☐ No			
c.		☐ Yes ☐ No			
d.		☐ Yes ☐ No			
e.		☐ Yes ☐ No			
f.		☐ Yes ☐ No			

2.	**Mental Health Issue/Condition – Date Updated:**	**Medication Prescribed**	**Date of Onset**	**Doctor/Practice Treating Issue**	**Client Perception of Severity of Condition**
a.		☐ Yes ☐ No			
b.		☐ Yes ☐ No			
c.		☐ Yes ☐ No			
d.		☐ Yes ☐ No			
e.		☐ Yes ☐ No			
f.		☐ Yes ☐ No			

Known Allergies	Reaction

MEDICATIONS - Date Updated:							
List Medications (including supplements and over the counter)		Prescribed for condition # above	Dose	Frequency	Date prescribed	Prescribing Physician	Pharmacy
a.							
b.							
c.							
d.							
e.							
f.							
g.							
h.							
i.							

SECTION F: OTHER INFORMATION THAT IS IMPORTANT TO KNOW ABOUT ME (OPTIONAL)

SECTION G: SIGNATURES

Signature	Date	Relationship