

Transitions to Community Living - Referral Screening Verification Process (RSVP)

The purpose of completing this referral is to initiate a screening for TCLI**. All fields are required unless indicated otherwise.**

The Transitions to Community Living Initiative (TCLI) provides eligible adults living with serious mental illnesses the opportunity to choose where they live, work, and play in North Carolina. This initiative promotes recovery through providing long-term housing, community-based services, supported employment, and community integration. See the DOJ settlement for further details.

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| --- | --- |
| Referrer Role |  |
| * Individual Seeking Services * Guardian * Hospital | * LME-MCO * Provider * Standard Plan * Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Are you submitting a SPH in-reach referral?

* Yes  No

Does the individual being referred have a guardian?

* Yes  No

If the individual has a guardian that is considered a “guardian of the person” or “general guardian,” but **not** the “guardian of the estate,” that guardian **must** be notified **before** making the referral.

* The individual completing the referral has received consent **from the individual being referred** OR **from the guardian** to contact the LME-MCO for a diversion screening.

If the individual has a guardian:

Guardian first name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian phone number: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email (optional): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referrer

first name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_

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Last name:

\_\_\_\_\_\_\_\_\_\_\_

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Referrer phone number:

(

\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Individual first name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Individual date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Individual gender:

* Male  Female  Other

Individual phone number: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email (optional): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Location of individual at time of referral

Name of facility, hospital, or shelter (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



Individual’s location type

* Facility (ACH/.5600 licensed/SNF)  Incarcerated
* State psychiatric hospital  With family/friends (temporarily)
* Community hospital  Residing in private residence
* Homeless (boarding house/hotel/shelter)

Individual’s location address (if a facility): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Individual’s location address city: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_ ZIP \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- |
| Reason for referral (select all that apply) |  |
| * Mental health  Intellectual/development * Substance use disability * Traumatic brain injury (TBI)     Potential mental health diagnoses (select all that apply) | * Medical: Medical diagnosis:   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   * Personal care services (PCS) |
| * Bipolar I disorder  Major depressive disorder * Bipolar II disorder  Schizoaffective disorder * Borderline personality disorder  Schizophrenia * Delusional disorder  Paranoid schizophrenia     Is the individual potentially eligible for Medicaid? | * Post-traumatic stress disorder   (PTSD)   * Unknown |
| * Yes  Application Pending * No  Have not applied |  Unknown |

Medicaid number if known, or last four digits of Social Security number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Individual Medicaid County or County of residence: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Add any additional information, if applicable, about the individual that you think is necessary to assist in the screening process (ex: past hospitalizations, medications, history of diagnoses, medical conditions, other insurance coverage, etc.)

*Please provide contact email address and telephone so that collateral documentation can be gathered during the upcoming screening process. Please also* ***list*** *the collateral documents that can be provided. (Example: abcd@maryshospital.com, 555-555-1234, Comprehensive Clinical Assessment, Psychological Assessment, Hospital Intake/Discharge paperwork, etc.)*

Paper Referrals should be submitted to DMH/DD/SUS.

**FAX:** OR **Mailing Address:** **For RSVP questions and technical**

919-508-0953 *Attention:* Mental Health Section – RSVP **assistance, please contact:**

3001 Mail Service Center RSVP.referral@dhhs.nc.gov

Raleigh, NC 27699-3001