COMMUNITY SERVICES, HOUSING, AND COMMUNITY DEVELOPMENT DEPARTMENT
Kathleen Torella, Director

Spokane County Supportive Living Program

Referral Packet Provider Agreement

As an Enrolled Mental Health Care Provider (MHCP) requesting ancillary services with Spokane County Supportive Living Program (SLP) I agree to actively participate in treatment and discharge planning. I will maintain regular scheduled appointments with the individual as well as contact SLP ancillary service providers with treatment goals and discharge plans. I agree that once an SLP Specialist has been assigned to the referral that a scheduled meet & greet will take place within 30 days to introduce the individual to SLP services and to discuss treatment plans, concerns and criteria for services.

Printed Name_____ Agency _____

Signature _____ Date _____

Required Attachments

☐ SLP Referral Request From (form will need to be completed with all lines addressed and appropriate boxes checked, if not it will be returned. All diagnosis **codes** - I, II, III, and IV - will need to be listed in **ICD10/DSM5 code format** (*descriptions only will not be accepted*)

☐ Intake Assessment form-most current form

Intake Assessment will need to include the following items:

- Substance abuse history-including past and current treatment
- Smoking-amount of tobacco a person smokes
- Legal History-past and current
- Gambling history

☐ Agency ROI

☐ Most Current Treatment Plan

☐ Crisis Plan/Risk Assessment ☐ MHCP reports individual does not require crisis plan

If enrolled MHCP discontinues services, SLP is to be notified on the same date as to ensure coordination of discharge

Please return this form with the completed SLP Referral Request form and all required attachments