COMMUNITY SERVICES, HOUSING, AND COMMUNITY DEVELOPMENT DEPARTMENT
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Supportive Living Program/Community Integration Program/ Housing and Recovery Through Peer Services Provider Referral Request

Individual's Name:_____ **Referral Request Date:** _____

DOB:_____ **Marital Status:** _____

Social Security #:_____ **Ethnicity:**_____

Provider One ID#:_____ **Currently Homeless?** ☐ **Yes** ☐ **No**

Current Address:_____ **Phone Number:**_____

Alternative contact information: _____

Guardian/POA: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Payee: _____ Phone: _____

Are you enrolled in services with another behavioral health agency? ☐ No ☐ Yes – If Yes, please indicate provider below:

☐ CC ☐ CHSW ☐ FBH ☐ LCS ☐ YFA ☐ SPARC ☐ Passages ☐ Native Project ☐ STARS

☐ Other: _____

Clinician Name: _____Phone & Extension: _____ Email: _____

Medical Provider Name (PCP): _____ Phone: _____

***Please complete a Release of Information for all medical and behavioral health providers.**

Diagnosis Code(s) (ICD10/DSM5 Format): Primary: _____ **Secondary:** _____ **Tertiary:** _____

Nursing or Medical Issues (Please list medical conditions that require medication or special care by staff) Attach Medical History and Physical Assessment, if indicated. _____

Special Accommodations (wheelchair, interpreter, etc.) please describe: _____

Any psychiatric, inpatient, crisis stabilization, or substance use disorder withdrawal management or residential treatment in the last year? ☐ No ☐ Yes – If Yes, name of facility(ies) and dates: _____

Legal Status: ☐ Voluntary LRA (Expiration date: _____) ☐ Conditional Release Estimated Release Date: _____

Housing Current and History (List Evictions and Dates): _____

Household Funding/Income

☐ TANF (Cash)	Amount: $	☐ Employment Income	Amount: $
☐ SSI	Amount: $	☐ ABP/ABD	Amount: $
☐ SSA-D/SSDI	Amount: $	☐ Other (describe):	Amount: $

Legal History: _____

_____

☐ Probation/ Parole CCO: _____ Expires: _____

Behavior History (all boxes must be marked)

	Yes	No	Unknown		Yes	No	Unknown
Gambling				Evictions – Explain above			
Assault without weapon				Fire Setting			
Assault with weapon				Unsafe Fire Practices			
Threatens physical harm				Currently Uses Tobacco?			
Property Damage				Sex Offender			
Substance Use				HX of suicide attempt/gesture			
Other History:							

If yes, please explain or attach documentation (i.e. Psychiatric Assessment or Psychosocial Assessment.)

_____

_____

Identified Needs of Individual

Service(s) requested:

☐ Supportive Living Services (SLP) ☐ Community Integration Program (CIP)

☐ Housing and Recovery Through Peer Services (HARPS)

☐ Community adjustment and resources	☐ Money Management
☐ Grocery shopping	☐ Self-care
☐ Housekeeping	☐ Meal planning & preparation
☐ Health care	

All are required for SLP/HARPS/CIP Services:

☐ **By signing below the individual attests and the provider confirms that:**

- **The individual is 18 years or older.**
- **The individual has a behavioral health diagnosis.**
- **The individual can be alone for days without supervision**
- **The individual is a minimal risk of danger to self, others or property.**
- **The individual possesses basic safety skills (call 911, safe with stove/hot water, etc.).**
- **The individual is Medicaid Eligible and enrolled with a Managed Care Organization.**

☐ **By submitting this form and signing below, the individual agrees to be evaluated for appropriateness for participation in SLP, HARPS and/or CIP programs. Completion of this form does not guarantee services from these programs.**

☐ **By signing below, it is acknowledged that at times SLP, HARPS, and CIP programs having waiting lists, and referrals are handled on a first come, first serve basis, unless the individual is determined to meet criteria for a priority population.**

☐ **As part of services with SLP, HARPS, and/or CIP the individual will be required to complete and follow an individualized service plan based on symptoms and needs.**

☐ **SLP, HARPS, and CIP are voluntary programs and participation is critical to success towards goals. The individual indicates that this is understood and agrees to participate in the program, if determined eligible, by signing below.**

Individual's Signature: _____ Date: _____

Clinician's Signature: _____ Date: _____

Spokane County Supportive Living Program/HARPS Program

Referral Packet Provider Agreement

As an Enrolled Mental Health Care Provider (MHCP) requesting services from the Spokane County Supportive Living Program (SLP), Community Integration Program (CIP) and/or Housing and Recovery through Peer Services program (HARPS), I agree to actively participate in treatment and discharge planning. I will maintain regularly scheduled appointments with the individual as well as contact SLP, CIP, and/or HARPS service providers with treatment goals and discharge plans. I agree that once an SLP Specialist, CIP provider, or HARPS peer has been assigned to the referral that a scheduled meet & greet will take place within 30 days to introduce the individual to services and to discuss treatment plans, concerns and criteria for services.

Printed Name_____ Agency _____

MHCP Signature _____ Date _____

Required Attachments

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

☐ Referring Provider Diagnostic Assessment form-most current.

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 an MHCP discontinues services, SLP, CIP, and/or HARPS is to be notified on the same date to ensure coordination of treatment.

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