SPOKANE COUNTY

COMMUNITY SERVICES DEPARTMENT

Justin Johnson, Director

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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 m inimal 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