Specialized Residential Transfer Verification Form

Attn: Ombudsperson, Adult Mental Illness

*** Verbal pre-authorization from Ombudsperson, Adult Mental Illness, **REQUIRED** for transfer

*** Upload Completed Form in **PDF format** onto the Residential Placement SharePoint site

Please complete all fields to ensure timely processing. Please complete and submit **no later** than the day after transfer if not sooner. All requests will be processed within 14 days of receipt.

Date: _____

Consumer Name: _____ **Age:** _____ **DOB:** _____

CMH #: _____

PCP Date: _____

Current Residence: _____

Authorization Number: _____

Move-in Date: _____ **Date of Transfer:** _____

Consumer will be transferred to (enter name of specialized residential facility): _____ **on (enter start date):** _____

1. Diagnosis (Axis I, II, III)
   a. I. _____, _____, _____, _____, _____
   b. II._____, _____, _____, _____, _____
   c. III._____, _____, _____, _____, _____

2. Case Management:
   a. HNBHS: ☐
   b. CSHS: ☐
   c. HHS: ☐
   d. CSI: ☐
   e. GNS: ☐

3. Guardian:
   a. Yes ☐
   b. No ☐
4. Insurance:
   a. Primary Insurance? _____
   b. Secondary Insurance? _____

5. Please indicate clinical rational for transfer? _____

6. Describe clinical progress made by consumer thus far: _____

7. Legal (Treatment Order/ NGRI): _____
8. Expected length of stay: _____
9. Consumer Input: _____
10. Guardian Input (if applicable): _____
11. Clinical Summary/ Narrative (if applicable): _____

Referral Source Information

Name/ Degree: _____ Email: _____

Position: _____

Phone Number: _____ Fax: _____

Referring Agency: _____ Supervisor: _____

Signature: _____ **Date:** _____
