Request for Inter-BHO Transfer

Referring BHO/County: ____ Date: ____________________

BHO Liaison Name: ____

Phone: ___________________________ Fax: _____________________________

E-mail: ____

Consumer Information:

Name: ____

DOB: _________________________ SSN: ________________________________

Ward: ________________ WSH Social Worker: ____

Phone: __________________________ E-mail: ____

Current Legal Status: ☐Voluntary ☐Civil Commitment ☐LRA ☐Criminal Commitment

Date of Next Hearing: _______________Income Source: ________________________________

Amount: $ Medicaid Eligible? ☐ Yes ☐ No

Receives Medicare? ☐ Yes ☐ No

Resources > $2000? ☐ Yes ☐ No

Community Case Manager: ____

Agency: ____

Case Manager Phone: ____________________ Fax: ________________________________

Reason for Referral: ____

____

- Is individual specifically requesting the referral for placement to this BHO? ☐Yes ☐No
  If yes, why?____
- Has independent housing been arranged and secured for the individual? ☐Yes ☐No
  If yes, please identify the type of housing:
  ☐ Apartment ☐ SNF ☐ Boarding Home ☐ AFH ☐ Other______________________________
- Is the request due to lack of residential resources in the referring BHO? ☐Yes ☐No
- Does the individual have natural supports available in the BHO requested? ☐Yes ☐No
  If yes, please describe:____
- Services needed by the consumer:____
- Discharge address (if independent placement):__________________________________

Packet is: ☐ Attached ☐In mail ☐ In box ☐ Faxed to __________________ ☐ E-mail (secure)

☐ Other ____

Signature of Referring BHO administrator or designee: ____________________________________

Date: ____________________

Signature of Receiving BHO Administrator or designee: ____________________________________

Date: ____________________