

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: _____

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- 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: _____