NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

# Transitions to Community Living - Referral Screening Verification Process (RSVP)

The purpose of completing this referral is to initiate a screening for TCLI**. All fields are required unless indicated otherwise.**

The Transitions to Community Living Initiative (TCLI) provides eligible adults living with serious mental illnesses the opportunity to choose where they live, work, and play in North Carolina. This initiative promotes recovery through providing long-term housing, community-based services, supported employment, and community integration. See the DOJ settlement for further details.

Referrer Role

☐ Individual Seeking Services
☐ Guardian
☐ Hospital
☐ LME-MCO
☐ Provider
☐ Standard Plan
☐ Other _____

Are you submitting a SPH in-reach referral?
☐ Yes ☐ No

Does the individual being referred have a guardian?
☐ Yes ☐ No

If the individual has a guardian that is considered a "guardian of the person" or "general guardian," but **not** the "guardian of the estate," that guardian **must** be notified **before** making the referral.

☐ The individual completing the referral has received consent **from the individual being referred** OR **from the guardian** to contact the LME-MCO for a diversion screening.

If the individual has a guardian:
Guardian first name: _____ Last name: _____

Guardian phone number: (_____)_____ Email (optional): _____

Referrer first name: _____ Last name: _____

Referrer phone number: (_____)_____ Email : _____

Individual first name: _____ Last name: _____

Individual date of birth: _____

Individual gender:
☐ Male ☐ Female ☐ Other

Individual phone number: (_____)_____ Email (optional): _____

Location of individual at time of referral
Name of facility, hospital, or shelter (if applicable): _____

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Individual's location type
☐ Facility (ACH/.5600 licensed/SNF) ☐ Incarcerated
☐ State psychiatric hospital ☐ With family/friends (temporarily)
☐ Community hospital ☐ Residing in private residence
☐ Homeless (boarding house/hotel/shelter)

Individual's location address (if a facility): _____

Individual's location address city: _____ State _____ ZIP _____

Reason for referral (select all that apply)

☐ Mental health
☐ Substance use
☐ Traumatic brain injury (TBI)
☐ Intellectual/development disability
☐ Medical: Medical diagnosis: _____
☐ Personal care services (PCS)

Potential mental health diagnoses (select all that apply)
☐ Bipolar I disorder
☐ Bipolar II disorder
☐ Borderline personality disorder
☐ Delusional disorder
☐ Major depressive disorder
☐ Schizoaffective disorder
☐ Schizophrenia
☐ Paranoid schizophrenia
☐ Post-traumatic stress disorder (PTSD)
☐ Unknown

Is the individual potentially eligible for Medicaid?
☐ Yes ☐ Application Pending
☐ No ☐ Have not applied
☐ Unknown

Medicaid number if known, or last four digits of Social Security number: _____

Individual Medicaid County or County of residence: _____

Add any additional information, if applicable, about the individual that you think is necessary to assist in the screening process (ex: past hospitalizations, medications, history of diagnoses, medical conditions, other insurance coverage, etc.)

*Please provide contact email address and telephone so that collateral documentation can be gathered during the upcoming screening process. Please also **list** the collateral documents that can be provided. (Example: abcd@maryshospital.com, 555-555-1234, Comprehensive Clinical Assessment, Psychological Assessment, Hospital Intake/Discharge paperwork, etc.)*

Paper Referrals should be submitted to DMH/DD/SUS.

**FAX:**
919-508-0953

OR

**Mailing Address:**
*Attention:* Mental Health Section – RSVP
3001 Mail Service Center
Raleigh, NC 27699-3001

**For RSVP questions and technical assistance, please contact:**
RSVP.referral@dhhs.nc.gov