CoP REFERRAL PACKET PROCESSING CHECKLIST

Name: Click here to enter text.

Address: Click here to enter text.

DOB: Click here to enter text.

Diagnosis: Click here to enter text.

|  |  |  |  |
| --- | --- | --- | --- |
| PACKET CONTENTS | YES | NO | DATE/  INITIALS |
| CoP Referral letter including statements  (page 3 of this referral packet) |  |  |  |
| Comprehensive Risk Assessment  (or page 2 of this referral packet if a RA has not been completed yet) |  |  |  |
| Person Centered Risk Management Plan |  |  |  |
| Behavior plan  (only if there is NO Risk Management Plan) |  |  |  |
| Does the individual have ITS level funding  (no documentation required; just answer yes or no) |  |  |  |
| Statement of acceptance or non-acceptance by Intensive Services Program  (if non-acceptance; please provide a list of RFPs that have been sent and their responses) |  |  |  |
| Consent to enter program (from individual/guardian/court) |  |  |  |

**RA/RMP ADDENDUM**

If a Comprehensive Risk Assessment and/or Person Centered Risk Management Plan *has not yet been performed for this individual*:

1) Mark the NO box with today’s date and your initials.

2) In the space below, ***explain the static and dynamic risks for this individual, and how they correspond to the treatment intensity, intensive supervision and environmental supports the Intensive Services Program has proposed for this individual***. Also please add your full name and the date.

Click here to enter text.

Insert agency logo

Date:

RE: CoP Cover Letter

To Community of Practice Members:

Please accept the attached referral packet regarding placement of [client name] for your review.

**Please consider the following as a statement of urgency for placement and supports needed;**

**Please consider the following as a statement of Ongoing/Returning care:**

[Agency name] is committed to serving [client name], coordinating his /her care and supporting him/her over the course of his/her upcoming transition (and future transitions). We are committed to collaborating with [program name] to ensure [client name] treatment and support needs are met.

Respectfully submitted,

Signature of Referral Author and Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Area Agency Executive Director or designee \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_