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
☐ Other ______________________________

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 (optional): _____________________________________

Individual first name: _____________________________ Last name: ____

Individual date of birth: ___________________________

Individual gender:

☐ Male ☐ Female ☐ Other

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

Name of facility, hospital, or shelter (if applicable): ____

Referral location type

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

Referral location address (if a facility): ____

Referral 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
☐ No
☐ Application Pending
☐ 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/SAS.

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