DWIHN Pre-placement Member Referral/Initial Plan

(To be faxed to Pre-placement Provider/Staff, CRSP Supports Coordinator, & DWIHN Residential Services @ 313-989-9525)

Member Name:			MHWIN ID#:
Date of Birth:		Social Security #:	
Supports Coordinator:			Phone#:
Clinically-Responsible Service Provider (CRSP):			Phone#:
Pre-placement Facility:			Phone#:
Outpatient Appointment Scheduled?	☐ YES ☐ NO	Date:	Time:
Member has Medicaid?	☐ YES ☐ NO	Facility:	
SSI / SSD?	☐ YES ☐ NO	Appointment With:	
Medicare?	☐ YES ☐ NO		

Referral Made By:				
☐ **COPE**	☐ **CRSP**	**Person completing form:**		
☐ **DWIHN UM**	☐ **RCS | RCC**	**Phone#:**	**Date:**	
Has Member Agreed to Residential Pre-placement (signed form):			☐ **YES**	☐ **NO**
Initial Plan (special diet, safety precautions, any unusual needs/circumstances):				
Authorized # of Days:		**From:**	**Through:**	

Intervention Plan

Observation:

☐ No Restrictions

☐ Full Restrictions until seen by primary treatment team

Risk Behaviors / Monitoring

☐ Physical Health Conditions: ______________________

☐ Self-injurious Behaviors: ______________________

☐ Physically Aggressive/Property Destruction: ______________________

☐ Non-compliant with Medications: ______________________________

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☐ Auditory/Visual Hallucinations: ______________________________

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☐ Substance Abuse: ______________________________

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☐ Preferred Placement (Facility Name): ______________________________

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☐ Other: ______________________________

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______________________________ ______________

Signature of Person Completing Form **Date**

CC: DWIHN Residential Services
Clinically-responsible Service Provider (CRSP)