

**HOME AND COMMUNITY BASED SERVICES-ADULT MENTAL HEALTH (HCBS-AMH)
REFERRAL FORM
STATE HOSPITAL**

Date of Assessment: ____/____/____	Commitment Type: Civil <input type="checkbox"/> Forensic <input type="checkbox"/>	Individual's Preferred Language: _____
First Name: _____	Last Name: _____	CARE ID: _____
Performed by: _____	Credentials: _____	Case ID: _____

I. COMMUNITY READINESS

- Does the individual meet HCBS-AMH Initial Eligibility Criteria (1095 days, cumulatively, in a psychiatric facility during the past five years)?
 Yes No
- Does the individual require a skilled nursing facility or higher level medical hospital due to a medical or physical condition?
 Yes No
- Is the individual waiting on the appointment of a guardian?
 Yes No
- Does the individual have an Intellectual Developmental Disorder (IDD) diagnosis?
 Yes No
If yes, what is the individual's severity level?
 Mild (IQ 55-70); Moderate (IQ 40-55); Severe (IQ 25-40); Profound (IQ < 25)
- What Medicaid services did the individual receive in the community prior to admission to the state hospital?

- Was the individual enrolled in LTSS, CLASS, TxHmL, or a Waiver program prior to admission? Yes No

II. RISK ASSESSMENT

- Has the individual been determined manifestly dangerous?
 Yes No
- Does the individual have a history of sexual aggression or predatory behavior?
 Yes No
If yes, how recent was this behavior: Within past 30 days; Within past 60 days; Within past 90 days; Greater than 90 days
- Does the individual have a history of acts that include repeated cruelty to animals and/or people?
 Yes No
If yes, how recent was this behavior: Within past 30 days; Within past 60 days;

Within past 90 days; Greater than 90 days

4. What is the current level of supervision required for the individual?

No Heightened Supervision; Within Eye Sight; Within 10 feet (close proximity); Within 10 feet 2:1 (2 staff:1 individual); Q30 (check individual every 30 minutes); Q 15 (check individual every 15 minutes)

5. Has the individual experienced physical restraint/s due to violence?

Yes No

If yes: Weekly; Monthly; Greater than monthly

III. FORENSIC COMMITMENTS ONLY

1. Please check the appropriate box and attach a copy of the standardized violence risk assessment that has been conducted with the individual? VRAG; HCR-20; PCL-R; COVR

IV. NOTES AND COMMENTS

V. PREFERRED COUNTY OF RESIDENCE

1. List individual's preferred county of residence if enrolled in HCBS-AMH: _____

VI. INDIVIDUAL AND LAR CONTACT INFORMATION

Individual's Contact Info:

Name: _____

Address: _____

Phone #: _____

LAR (if applicable) Contact Info:

Name: _____

Address: _____

Phone #: _____

