Community Inclusion Planning Meeting Referral Form

Community Inclusion Planning Meetings are only offered to Alliance Health members and recipients.

General information *

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Today's date (mm/dd/yyyy) _____ County _____

Urgency of request: ◯ Within 14 days ◯ Within 30 days

Reason for meeting:
- ◯ Community connection
- ◯ Residential/Institutional Discharges
- ◯ Exhaustion of resources known to team
- ◯ Follow up from previous CIPM
- ◯ Other (Specify) _____

Referral information *

Members may refer themselves. If this is the case, please write 'Self' in the referral source.

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Referral source _____ Title _____

Agency/Provider _____

Email _____ Phone _____

Member information *

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Full name _____ Date of birth (mm/dd/yyyy) _____ Age _____

Address line 1 _____ (Street, P.O. Box, etc.) Address line 2 _____ (Suite, Building, etc.)

City _____ State _____ Postal code _____

Email _____ Phone _____

Gender identity:
- ◯ Male
- ◯ Female
- ◯ Non-binary
- ◯ Prefer not to answer

Preferred pronouns:
- ◯ She/her/hers
- ◯ He/him/his
- ◯ They/them/theirs
- ◯ Other (please specify) _____

How would you like to be contacted? ◯ Email ◯ Phone

Current status/Living arrangement:
- ◯ Independent living
- ◯ Group home
- ◯ Jail/Prison
- ◯ Homeless
- ◯ Hospital
- ◯ Other (please specify) _____

Do we need to consider any of the following when scheduling the Community Inclusion Planning Meeting? ◯ No
- ◯ American Disabilities Act*
- ◯ Location
- ◯ Non-English Speaker *
- ◯ Time
- ◯ Other
- ◯ Please specify accommodation: _____

*If member needs an interpreter, referral source is responsible for securing an interpreter

Legal guardian information

☐ N/A

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Full name _____

Email _____ Phone _____

Relationship to member:

- ◯ DSS
- ◯ Parent
- ◯ Relative
- ◯ Other (Specify) _____

Needs expressed by the member *

Please complete this section with the member. This section will inform who attends the Community Inclusion Planning Meeting as well as help us understand the priorities of the member.

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Discuss the member's strengths, goals, and interests:

How are you (the member) hoping the Community Inclusion Planning Meeting process can help you?

What needs would you like addressed in the following areas (check all that apply):

- ☐ Educational
- ☐ Emotional/Psychological
- ☐ Vocational/Employment
- ☐ Financial
- ☐ Mental health
- ☐ Housing
- ☐ Legal
- ☐ Physical health
- ☐ Social/Recreational
- ☐ Spiritual
- ☐ Transportation
- ☐ Other (please specify) _____

Please check any supports or resources currently in place (check all that apply):

- ☐ ACTT
- ☐ Adult Probation/Parole
- ☐ Care Coordination
- ☐ Counselor/Therapist
- ☐ Dental Care
- ☐ DSS/CPS
- ☐ Employment
- ☐ Enrolled in School/Day Treatment/Homebound
- ☐ Food Assistance
- ☐ Housing Assistance
- ☐ IDD Services
- ☐ Medication Management
- ☐ Mentor/Other support
- ☐ Other group/program
- ☐ Primary Care Physician/Doctor
- ☐ Recreational Programs
- ☐ Reliable Transportation
- ☐ SSI/SSDI
- ☐ Spiritual
- ☐ Substance Use Treatment
- ☐ Unemployment benefits
- ☐ VA benefits
- ☐ Vocational Rehabilitation
- ☐ Work First
- ☐ Other (specify): _____

Any additional concerns?

Please list any natural supports (family, spiritual, friends, mentors, groups or activities):

Please provide a summary of services or resources that have been explored in the last six to twelve months.

Please attach additional pages if needed to provide details.

Additional information *

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Is the member connected to a Behavioral Health provider? ◯ Yes ◯ No

Please list the clinical home _____

Has the member been admitted to the hospital for psychiatric care in the past 3 months? ◯ Yes ◯ No

Has the member been admitted to a crisis facility in the past 3 months? ◯ Yes ◯ No

If yes, which facility? _____

Has the member been admitted to the hospital for NON-psychiatric care in the past 3 months? ◯ Yes ◯ No

Is the member connected to a primary care physician? ◯ Yes ◯ No

Please list the medical home _____

Has the member had a preventive medical screening in the past 6 months from a primary care physician? ◯ Yes ◯ No

Does the member have a treatment or support team that meets regularly? ◯ Yes ◯ No ◯ N/A

Date of last meeting (mm/dd/yyyy) _____

If applicable, please provide the name and contact info of the adult probation officer:

First name _____ Last name _____

Email _____ Phone _____

Submission instructions

Please submit the completed form to CHWBreferrals@alliancehealthplan.org.

For internal use only

Referral status

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◯ Accepted ◯ Assist (Community Connection) ◯ Denied (provide reason): _____

_____

CIPM Coordinator _____ Date (mm/dd/yyyy) _____