AMENDMENT 3
AMENDED AND RESTATED
FY2026 AND FY2027 COMMUNITY SERVICES PERFORMANCE CONTRACT
MASTER AGREEMENT
Exhibit K
Appendix A - OUT OF CATCHMENT NOTIFICATION TEMPLATE

OUT OF CATCHMENT REFERRAL INSTRUCTIONS

The out of catchment referral is to be used when individuals are being discharged from the state hospital to a catchment area that is outside of the originating CSB's area. The form is utilized to provide information about the individual, as a referral for needed services, and notification for emergency services.

The form has two parts: notification and referral.

For individuals residing short term in another catchment area, or individuals not engaged in CSB services:

- **Please complete page 1- Notification-** This page provides necessary information for CSBs to be aware of individuals discharging from state facilities who are temporarily in another catchment area, or individuals discharging to a catchment area that will not be referred to CSB services.

For individuals being placed in another catchment who will require CSB services AND/OR have a DAP plan for services in another catchment area:

- **Please complete the entire referral form**
- **Please provide documentation including any EHR face sheet and most recent assessments. Additionally, at discharge, please provide the hospital discharge information to the accepting CSB.**

If the individual has a DAP plan, please be sure to submit the narrative and IDAPP to the accepting CSB and the regional manager.

OUT OF CATCHMENT NOTIFICATION/REFERRAL FORM

☐Notification Only *(Page 1)* ☐Full Referral (*Pages 1-3; for individuals who will be referred for services)*

Patient Name:

Last 4 of SS#: DOB: Click or tap to enter a date.

State Hospital: Choose an item.

Admission Date: Click or tap to enter a date.

Primary Diagnosis:

Anticipated Discharge Date: Click or tap to enter a date. Next Treatment Team Date:Click or tap to enter a date.

Social Worker: Phone Number:Click or tap here to enter text.

Current CSB: Choose an item.

Name of Contact:

Phone: Email:

CSB of Discharge Residence: Choose an item.

Name of Contact:

Phone: Email:

Discharge Address:

Type of Residence:

Phone Number:

Contact at Residence (if applicable):

Does this individual have a legal guardian or POA? Choose an item.

(If yes, please list below under "Emergency Contact")

Emergency contact:

Address:

Phone:

Does this individual have a conservator or payee? Choose an item.

Name:

Address:

Phone:

Will this individual be referred for any services at CSB of discharge residence? Choose an item.

(If yes, please complete the remaining pages of this form.)

I. **Previous Housing** – Please list the individual's housing prior to admission to the state hospital:

Type of Housing:

Name of Residence (if applicable):

Reason Not Returning:

II. **Entitlements and Funding Sources**

☐SSI/SSA Amount:

☐SSDI Amount:

☐Medicaid List # and Type:

☐Medicare List # and Type:

☐DD Waiver Choose an item.

☐Auxiliary Grant Local DSS office where application sent:

☐SNAP

☐VA Benefits Click or tap here to enter text.

☐Private Insurance List Type and #:

☐Other:

III. **DAP**

Type: Choose an item.

Reason Needed:

IV. **Community Support** – What type of community-based services will be required?

☐Case Management

☐PACT/ICT

☐Mental Health Skill Building

☐Psychosocial Rehabilitation

☐Employment Services:

☐Substance Use Services:

☐Outpatient Services:

☐Other:

☐DAP Monitoring

V. **Legal Status**

Does individual have a valid ID? Choose an item.

Does the patient have any existing/pending criminal charges or court dates?Choose an item.

List Charges:

Court:

Court Date(s):

Is the individual NGRI? Choose an item. If yes please follow NGRI protocols.

VI. **Safety and Support Plan/Crisis Plan Initiated?** - Choose an item.

(If Yes, please attach)

VII. **Electronic Signature**

Notifying/Referring CSB: _____ Date: _____

Referral Sent to: Click or tap here to enter text.

Date: Click or tap to enter a date.

Referral Communication Method:Choose an item.