



Sending Fax:

Date:

Receiving Fax:

**Client Name:**

**Client ID:**

**DOB:**

Referent:

Referent's Phone:

Response by:

Responders Phone:

**Referral to Program/County:**

Adult Residential Treatment

Aurora House

**Section A**

How will this level of service benefit this individual?

Special risk issues that will be relevant to the program (i.e. outreach safety, residing in a facility with vulnerable adults)

## Section B

### Adult Residential Treatment referrals please complete:

#### Admission Criteria (Mark all that apply)

- The client is 18 or older
- Currently meets eligibility criteria for publicly funded outpatient mental health services (and has completed or is scheduled for Mental Health Assessment).
- Due to a covered mental illness, requires 24-hour supervision to live successfully in community settings
- Is medically stable and free of physical condition(s) requiring medical or nursing care beyond what the residential facility can provide within the scope of their license
- Is ambulatory
- Has sufficient cognitive and physical abilities to enable response to fire alarms
- Has not required physical restraint in the past 30 days.
- Meets WAC requirements for WAC 246-337.
- Has met a LOCUS level of 5 or 6 due to a mental illness per current LOCUS/CALOCUS

#### Residential Exclusionary Criteria

- The client has a psychiatric condition that qualifies for a more intensive/restrictive residential option.
- The client is actively suicidal or homicidal.
- The client is chemically dependent on alcohol and/or drugs and is in need of detoxification.
- The client has a primary diagnosis of Developmental Delay, Intellectual Disability, or Autistic Disorder/Autism Spectrum Disorder.
- The client has a recent history of arson, serious property damage or infliction of bodily injury on self or others. (This exclusion can be waived based upon the accepting facility's evaluation of the client's functioning.)

## Section C

### To be completed by individual referred: (adult programs)

- I agree to receive services from the specified program:

**Client Signature:**

**Date:**

- Client has been educated about the program and agrees to participate in the specified service but is not willing to sign the form

Please email this form to [Residential@compassh.org](mailto:Residential@compassh.org)

*\*In addition to this form please include the Mental Health Assessment, Psychiatric Assessment, Treatment Plan, Most recent 2 psychiatric services notes, and 30 days of Outpatient Treatment Notes, as well as any other documents you wish to be considered*