St. Clair County Community Mental Health Authority

Program Placement/Transfer Meeting Checklist

Attachment to #0041/#0041-B

Individual:_____ Case #:_____ Date:_____

REFERRING CASE HOLDER

TREATMENT PLAN IMPLICATIONS (Check if applicable):

Personal Care: ☐ New Plan ☐ Review

FUTURE TIMEFRAMES (Fill in due dates or indicate N/A)

Activity	Due Date
Periodic Review	_____
Person-Centered Plan	_____
Assessment	_____
Medication Review	_____
Injection- ☐ Yes ☐ No	_____
AIMS	_____
Consents	_____
Financial Information	_____
OLD Program Close Case (CMS) Effective:	_____

OTHER:

- ☐ Case Record Transmittal
- ☐ Known Missing Documents:
  _____
  _____
- ☐ Consumer Satisfaction/Transfer

_____ _____
Referring Case Holder Signature/Credentials Date

_____
Print Name

_____ _____
Receiving Case Holder Signature/Credentials Date

_____
Print Name

RECEIVING CASE HOLDER

OTHER FORMS/MICELLANEOUS ITEMS (check all those needed):

- ☐ Update Client Intake Forms (Facesheet)
- ☐ Treatment Authorization
- ☐ Model Payment Processing
- ☐ Level of Care Determination (DSS 3471) (Required when entering **and** exiting licensed settings)
- ☐ Consents Needed (list all those needed):
  _____
  _____
  _____
- ☐ Financial/Insurance Information (list all new financial forms needed):
  _____
  _____
  _____
- ☐ Benefit Application Needed
- ☐ Spenddown from Medicaid ☐ Yes ☐ No
  Amount: _____
- ☐ Transportation Arrangements: _____
  _____
- ☐ Address Change
- ☐ Staff Training Needed: _____
  _____
  _____
- ☐ Court Processing Needed: _____
  _____
- ☐ Service Provider Enrollment: _____
- ☐ Provider Contract Needed
- ☐ Notification Required to:
  - ☐ Administration
  - ☐ School District
  - ☐ FIA
  - ☐ Other: _____

Clinical Form: #03-0041C
Reviewed Date: 11/26/2024
Admin Procedure Ref: #03-002-0065
EHR: Services, Placement/Transfers Note: Transfer Checklist

RECEIVING CASE HOLDER cont.

- ☐ Level of Functioning Needed
- ☐ 7 Day Interim Plan
- ☐ Assessments Ordered:
  - ☐ CSM ☐ RN ☐ OT
  - ☐ Clinical ☐ Other
- ☐ PCP Amendment
- ☐ PCP Attachment A
- ☐ H/SW Changes Notification
- ☐ Evacuation Assistance Score
  - ☐ EDI Update
- ☐ Foster Care per Diem Determination

FUTURE TIMEFRAMES (Fill in due dates or indicate N/A):

Activity	Due Date

NEW Program(s) Open Case (CMS), Effective: _____

Individual/Family Contact Required Within: _____

Clinical Form: #03-0041C
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