



## Transitions to Community Living - Referral Screening Verification Process (RSVP)

The purpose of completing this referral is to initiate a screening for TCLI. **All fields are required unless indicated otherwise.**

The Transitions to Community Living Initiative (TCLI) provides eligible adults living with serious mental illnesses the opportunity to choose where they live, work, and play in North Carolina. This initiative promotes recovery through providing long-term housing, community-based services, supported employment, and community integration. See the DOJ settlement for further details.

### Referrer Role

- Individual Seeking Services  
 Guardian  
 Hospital

- LME-MCO  
 Provider  
 Other \_\_\_\_\_

Does the individual being referred have a guardian?

- Yes  No

If the individual has a guardian that is considered a “guardian of the person” or “general guardian,” but **not** the “guardian of the estate,” that guardian **must** be notified **before** making the referral.

The individual completing the referral has received consent **from the individual being referred OR from the guardian** to contact the LME-MCO for a diversion screening.

If the individual has a guardian:

Guardian first name: \_\_\_\_\_ Last name: \_\_\_\_\_

Guardian phone number: (\_\_\_\_) \_\_\_\_\_ Email (optional): \_\_\_\_\_

Referrer first name: \_\_\_\_\_ Last name: \_\_\_\_\_

Referrer phone number: (\_\_\_\_) \_\_\_\_\_ Email (optional): \_\_\_\_\_

Individual first name: \_\_\_\_\_ Last name: \_\_\_\_\_

Individual date of birth: \_\_\_\_\_

Individual gender:

- Male  Female  Other

Individual phone number: (\_\_\_\_) \_\_\_\_\_ Email (optional): \_\_\_\_\_

Name of facility, hospital, or shelter (if applicable): \_\_\_\_\_



NC DEPARTMENT OF  
**HEALTH AND  
HUMAN SERVICES**

Referral location type

- Facility (ACH/.5600 licensed/SNF)
- State psychiatric hospital
- Community hospital
- Homeless (boarding house/hotel/shelter)
- Incarcerated
- With family/friends (temporarily)
- Residing in private residence

Referral location address (if a facility): \_\_\_\_\_

Referral location address city: \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Reason for referral (select all that apply)

- Mental health
- Substance use
- Traumatic brain injury (TBI)
- Intellectual/development disability
- Medical: Medical diagnosis: \_\_\_\_\_
- Personal care services (PCS)

Potential mental health diagnoses (select all that apply)

- Bipolar I disorder
- Bipolar II disorder
- Borderline personality disorder
- Delusional disorder
- Major depressive disorder
- Schizoaffective disorder
- Schizophrenia
- Paranoid schizophrenia
- Post-traumatic stress disorder (PTSD)
- Unknown

Is the individual potentially eligible for Medicaid?

- Yes
- No
- Application Pending
- Have not applied
- Unknown

Medicaid number if known, or last four digits of Social Security number: \_\_\_\_\_

Individual Medicaid County or County of residence: \_\_\_\_\_

Add any additional information, if applicable, about the individual that you think is necessary to assist in the screening process (ex: past hospitalizations, medications, history of diagnoses, medical conditions, other insurance coverage, etc.)

*Please provide contact email address and telephone so that collateral documentation can be gathered during the upcoming screening process. Please also list the collateral documents that can be provided. (Example: abcd@maryshospital.com, 555-555-1234, Comprehensive Clinical Assessment, Psychological Assessment, Hospital Intake/Discharge paperwork, etc.)*

Paper Referrals should be submitted to DMH/DD/SAS.

**FAX:** 919-508-0953      **OR**      **Mailing Address:**  
*Attention:* Mental Health Section – RSVP  
 3001 Mail Service Center  
 Raleigh, NC 27699-3001

**For RSVP questions and technical assistance, please contact:**  
[RSVP.referral@dhhs.nc.gov](mailto:RSVP.referral@dhhs.nc.gov)