RADIAS
HEALTH
Welcome to a full circle of care.

RADIAS Health RSS Referral form

Form must be completed in full

Client Name: First _____ Last _____ MI _____

Date of Birth: _____

Current Address: Street _____

City _____ State _____ Zip _____

Gender: Male Female Non-binary/third Gender Prefer to identify as _____

Race/Cultural identity: _____

MA/PMI #: _____

SSN: _____

Date Residential Service Requested: _____

Civil Commitment Status: _____

Jarvis: Yes or No

County of Financial Responsibility: _____

Mental Health DSM V Diagnosis: _____

_____

_____

_____

_____

Other: _____

Physical Health Conditions: _____

_____

_____

Income Source:

- ☐ **SSI (Supplemental Security Income) : Amount _____**
- ☐ **SSDI (Social Security Disability Income) : Amount _____**
- ☐ **Temporary Assistance: Amount _____**
- ☐ **Other Please List: _____**

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RADIASHEALTH.ORG
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Has client had a CADI Screening? Yes No If yes, date: _____

Does client have a Guardian or Conservator? Yes No

If yes, name: _____

Does the client have a therapist? Yes No

If yes, name: _____

Phone #: _____

Does the client have a Psychiatrist? Yes No

If yes, name: _____

Phone #: _____

Does the client need awake overnight staff? Yes No (if no client is not a fit for RADIAS Heath RSS program)

What is the requested staffing Pattern? 2:4 or 1:4

As part of the referral please attach the following:

1. **Medication List**
2. **Historical Data**
3. **Most recent DA**
4. **Progress notes from current placement**

PLEASE Email RSS REFERRAL FORM AND INFORMATION TO:

Attention: Emily Boulay

Email: rssreferrals@radiashealth.org

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